Residential Aged Care

Complaints to the Health and Disability Commissioner: 2010–2014

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Feedback
We welcome your feedback on this report. Please contact Natasha Davidson at hdc@hdc.org.nz

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COMMISSIONER'S FOREWORD

HDC has an important leadership role in ensuring there are ongoing systematic improvements in safety and quality in the health and disability sector. Learning and improvement at a local level occurs in the majority of complaints that come to HDC, either in response to recommendations for change made by HDC, or due to providers proactively making changes in response to the issues raised by the consumer. However, it is important that the sector as a whole benefit from the learnings in complaints. We, at HDC, are harnessing our complaint data to allow the sector to learn from the trends and patterns that emerge from the data. With this in mind, I am pleased to present this analysis of complaints to HDC about residential aged care facilities.

Meeting the healthcare needs of our aging population is one of the challenges facing New Zealand's healthcare system. Residential aged care facilities dominate the provision of long-term aged care support in New Zealand. The residents of these facilities can often represent some of the most vulnerable members of our communities, and they are often dependent on clinical and non-registered staff for their complex healthcare needs and activities of daily living. Additionally, the care provided by staff is further complicated because these facilities are also where the resident lives. I am frequently impressed by the passion, dedication and skill of the staff working in this area, and most of the time the care provided is of a high standard. However, HDC's role is to stand in the margins where things do not go well, and it is important that the sector learns and changes in response to those events.

As you will see, certain trends in complaints about this sector are discernible and reflect what is known about the challenges of caring for an elderly population. A number of observations arise out of these trends, and from the individual cases described. Most notable for me is the importance of communication in residential aged care, both across the multidisciplinary team and with consumers, who may not be able to advocate for themselves, and their families. Such an environment relies on the principles of consumer engagement and seamless service.

I trust this report will prove useful to both providers in the sector and for those who use these services. When reading this report, I encourage providers to consider, "Could this happen at my place?" and, if so, what changes could be made to prevent it.

My thanks to all those who have shared their experiences and, in doing so, have made this report and the learning contained within it possible.

Anthony Hill
Health and Disability Commissioner

EXECUTIVE SUMMARY

This report analyses complaints made to the Health and Disability Commissioner between 2010 and 2014 about residential aged care facilities (RACFs). During that period, HDC received 502 complaints about care provided by RACFs, with an average of 100 complaints being made each year. As multiple RACFs are sometimes involved in a single complaint, and some RACFs received more than one complaint, this equated to 514 cases being analysed.

Failure to communicate effectively with family was the most common issue raised by complainants in regard to RACFs, being present for over half of the cases. Other common issues included: inadequate communication between providers; inadequate response to the complaint by the facility; hygiene needs not met; delayed/inadequate referral; and disrespectful manner/attitude.
When the issues were looked at over time, it was found that communication issues have consistently been the most commonly complained about issues, with failure to communicate effectively with family, inadequate communication between providers, and inadequate response to the complaint by the facility being among the most common issues each year. While complaints about hygiene needs not being met, wound management issues, and a disrespectful manner/attitude have become less prominent in recent years, complaints about inadequate post-fall assessment, mishandling of the consumer, and inadequate pain management have become more prominent.

Issues relating to fluid/nutrition were present in 16% of cases. Around a third of these cases related to the failure to start or accurately complete a fluid balance chart. These cases also often involved issues related to inadequate care planning and inadequate communication between providers.

Complaints alleging that a resident's pain had not been managed adequately by RACF staff were common, with it being at issue in 15% of cases. Many of these cases related to the provision of end-of-life care. Over a third of these cases involved a failure to carry out an adequate pain assessment, and often there were issues around communication between providers and with the resident's family.

Falls were at issue in 20% of cases, with this issue becoming more prominent in 2014. Many of these cases were in reference to post-fall assessments. Issues regarding communication between providers and missed/delayed diagnoses were also common in these cases.

Wound care was at issue in 15% of cases in the HDC complaint data; however, the proportion of cases for which a wound care related issue was complained about had decreased markedly over time. Communication with family, communication between providers, and inadequate care planning were also common issues in these cases.

Complaints regarding the recognition/management of a resident's deteriorating condition were common, with this issue being present in 22% of cases. 17% of these cases involved the inadequate assessment or monitoring of the resident's vital signs. These cases often also involved inadequate care planning, inadequate communication between providers, and delayed/inadequate referrals.

A common finding on assessment of complaints about RACFs is that a failure by staff to follow the facility's policy and procedures was a contributing factor to care deficiencies.

There are various learnings that arise from recommendations HDC has made to facilities when it has identified care deficiencies. These recommendations are detailed throughout the report.

BACKGROUND

1. Aged care in New Zealand

Residential aged care services in New Zealand

Residential aged care is a long-term care service for older people who have ongoing health and personal support needs that are at levels that cannot be provided for safely in the community. The care delivered in such settings is a mix of health and social services, including personal and nursing care. New Zealand's long-term aged care support is dominated by residential aged care facilities (RACFs), both in terms of funding and public profile. Legislation in New Zealand provides for four categories of RACFs, depending on the person's level of need:

- *Rest home:* provided for those whose needs are unable to be met safely in the community, but who do not require 24-hour nursing care.
- *Hospital-level care:* provided for those requiring 24-hour nursing care.
- *Specialist dementia service:* provided for those with the symptoms of dementia, who do not need 24-hour nursing care, but need specialist and secure facilities that minimise the risks associated with dementia.
- *Psychogeriatric services:* for those with the severe behavioural or psychological symptoms of dementia and who need intensive 24-hour nursing care.

In order to assess whether they qualify for DHB-contracted RACFs, older people in need of support receive a needs assessment from a government-funded needs assessment and service coordination organisation (NASC). People are eligible for residential aged care if they:

i. have had their support needs assessed as being high or very high, and indefinite (i.e., their condition cannot be reversed);
ii. have been assessed as being unable to have their needs safely supported within the community; and
iii. are aged 65 years or older (or aged between 54 and 64 years, unmarried and with no dependent children).

An aging population

Similar to other OECD nations, New Zealand has an aging population. Currently, 14% of the New Zealand population is aged 65 years and older, with this age group having increased by 55% since 2004. By 2034 it is expected that this age group will make up 22% of the population. There has been an even larger increase in those aged 80 years and over, with the number of people in this age group increasing by 80% between 1994 and 2014. By 2034, the number of people in this age group is expected to have increased by 130%. By comparison, over the same time period, the number of people aged under 20 years is expected to increase by only 3%.[1]

The growth in the aging population is placing, and will continue to place, pressure on the aged care sector in New Zealand. Age is an effective predictor of the health needs of a population. The prevalence of disability and chronic conditions increases with age and, consequently, the demand for RACFs increases rapidly with age in those aged over 65 years.[2] 59% of people aged 65 years and older are classified as disabled, compared with 21% of adults aged under 65 years.[3] The most common users of RACFs in New Zealand are those aged over 85 years[4] and, as outlined above, the size of this age group has shown a large increase in recent years.

The utilisation of RACFs in New Zealand is high by international standards.[4] Currently, around 31,000 older people reside in RACFs.[5] A recent study has found that about 47% of all New Zealanders over the age of 65 years will live in an RACF at some point and that, after the age of 85 years, 58% of men and 70% of women will move into an RACF.[4] Projections suggest that, assuming demographics are the determinants of demand, by 2026 demand for RACFs in New Zealand will have increased by approximately 78% since 2008.[2]

Older people living in RACFs

The New Zealand Government's Positive Ageing Strategy[6] and Health of Older People Strategy[7] promote "ageing in place" — supporting older people to remain living safely in the community. According to this approach, RACFs are appropriate only for older people who have been assessed as requiring "high" to "very high" support. While this may result in a lower proportion of the population entering RACFs, it also means that the older people who do enter RACFs will do so with higher levels of dependency and more complex healthcare needs.

A study of Auckland RACFs found that, between 1988 and 2008, the proportion of residents in the lowest category of dependence reduced from 16% to 4%, while residents with hospital-level care needs increased from 13% to 20%.[8] In particular, it was found that there was an increase in the proportion of incontinent residents and those who were confused and forgetful. It has also been found that a higher proportion of older people die in RACFs in New Zealand than in other OECD countries. In this country, 38% of the population who die aged 65 years or older die in RACFs, meaning that these facilities are also often providing end-of-life care.[9]

These levels of dependency mean that residents entering RACFs are often presenting with complex needs, multiple co-morbidities, and at a later stage of illness. This demands a higher level of care and skill from facilities than may have been the case in the past, and creates a further imperative to ensure quality service delivery.

2. Quality of residential aged care services

Monitoring quality of care in New Zealand — residential aged care audits

In New Zealand, under the Health and Disability Services Safety Act (the Act) RACFs are required to provide their residents with care that meets Health and Disability Service Standards (the Standards) in order to gain certification. All RACFs in New Zealand must be certified in order to provide care. All RACFs are audited by the Ministry of Health, through HealthCERT, in order to ensure that they are meeting the criteria set out in the Standards. Those RACFs that are found to be meeting the criteria are awarded longer certification periods.

The auditors rate the services provided by each facility against each criterion in the Standards to decide whether the Standards are being met and what actions need to be taken to improve the care provided to residents. The Standards include:

- *Consumer rights* — this includes checking that residents: are well informed of their rights; treated with respect; receive services in a manner that has regard for their dignity, privacy and independence; receive culturally safe services; are free from discrimination; are provided with the information they need to give informed consent; are able to maintain links with their family and community; and have their right to make a complaint respected and upheld.

- *Organisational management* — this includes checking: that the day-to-day operation of the service is managed in an efficient and effective manner; that there are enough staff with the necessary qualifications; that staff receive adequate orientation and training; that the facility has an established and maintained quality and risk management system; and that consumer information is accurately recorded, current, confidential and accessible.
- *Continuum of service delivery* — this standard ensures that residents receive care that is safe and appropriate to their needs. It includes ensuring: that residents receive a needs assessment when they enter a facility; that care planning is consumer-focused, integrated and promotes continuity of care; that care plans are evaluated in a comprehensive and timely manner; that access or referral to other health services is appropriately facilitated and provided; that consumers experience a planned and coordinated transition, discharge, or transfer from services; that consumers receive medicines in a safe and timely manner; and that a consumer's individual food, fluids and nutritional needs are met .
- *Safe and appropriate environment* — This includes ensuring that the physical environment is appropriate, safe and accessible.
- *Infection control* — This includes checking: that the facility's policies have adequate procedures to prevent infections spreading between residents and staff; that staff have received training in controlling infection; and whether there have been any outbreaks of infection and, if so, what the facility did in response.
- *Managing restraint safely* — Sometimes residents have to be restrained to prevent them from harming themselves or others. This standard is aimed at reducing the use of restraint so that it is used only when absolutely necessary. [10]

DHBs also monitor the quality of care that residents receive in RACFs. The facilities that receive the subsidy described above must enter into a contract with their DHB — the Age Related Residential Care Services Agreement (the ARRC Services Agreement). The ARRC Services Agreement sets out service specifications for facilities, including service philosophy, objectives, policies and procedures, and documentation. The Agreement requires that facilities have staff ratios that meet the needs of the residents, and that each resident receives a regular comprehensive needs assessment and an individualised care plan. Services must meet the requirements set out in the ARRC Services Agreement, and DHBs are required to monitor the performance of RACFs with which they hold an ARRC Services Agreement. DHBs have the ability to conduct issues-based audits under the ARRC Services Agreement. The audits conducted by HealthCERT also assess whether facilities are meeting the requirements as set out in the ARRC Services Agreement.

A recent report into RACFs in New Zealand found that an increased number of facilities were awarded a four-year certification period in 2015, compared to 2009. Data also showed that audits in 2015 resulted in fewer numbers of partially attained criteria in 2015 than was the case in 2009. This report concluded that changes made to the audit process between 2009 and 2015 had resulted in a greater quality of care and improved outcomes for residents, and that greater gains were made when auditors approached the process as a collaborative, quality-focused conversation, rather than as a data- focused examination.[11]

International literature on quality of residential aged care

RACFs, as well as providing clinical services, also provide residents with a place to live. Therefore, what constitutes quality of care in these facilities may be more complex and harder to define than in other healthcare settings. Two dimensions of quality are typically examined in relation to RACFs — quality of the clinical care provided and quality of life for the residents.

The majority of studies in this area tend to use clinical outcomes as a measurement of quality, rather than using quality as defined by residents and their families. This may be because the clinical aspects of services are more easily measurable and can be more objectively assessed.[12] The investigation of three areas of care has been suggested in order to ascertain quality of care within a facility: structure (the setting in which the care occurs); process (what is actually done in the provision of care); and outcome (the results of care). These areas are interlinked — good structures facilitate good processes, which facilitate positive outcomes.[13, 14] Quality indicators are then used to measure quality within these areas of care. Quality indicators are measurable elements of care that identify opportunities for improvement or areas requiring further investigation.[15] For RACFs, quality indicators tend to focus on high-risk clinical care areas for the elderly, for example, pressure ulcer rates, incontinence rates, infection rates, restraint rates, hydration management, polypharmacy, falls rates, and unplanned weight loss.[12, 16, 17, 18, 19]

However, the delivery of high quality clinical care results does not necessarily correlate with a high quality of life for residents. Studies of residents' perspectives on their quality of life within RACFs have found that autonomy, choice, control, privacy, and social relationships are important factors.[20–23] A 2012 systematic review of qualitative studies concluded that RACFs needed to make allowances within the facility's environment to provide a "home" that is person-centred for each individual, and where carers take into account each resident's personal preferences in order to allow them to maintain their autonomy, self-identity and independence.

International research has concluded that functional impairment and, therefore, a greater dependence on assistance, is associated with low care satisfaction among residents in RACFs.[25–27] These studies have also found that over half of those residents are dissatisfied with the influence they have over their care.[25, 26] The authors of these studies concluded that in order to improve care satisfaction, those who are dependent on care services need to be supported and empowered within the care environment.

A study of residents' perspectives in Western Australian RACFs found that satisfaction with staff care played a central role in determining all other aspects of resident satisfaction.[28] This is consistent with other international studies in the area which have stressed that the bottom line from consumers is that "without good staff nothing else is possible".[29] Researchers have concluded that the best way to enhance resident satisfaction is to enhance staff satisfaction, emphasising that staff must be valued as an important resource, and be trained, encouraged and empowered to deliver excellent care.[30]

3. Using complaint data to identify trends in service provision

Complaints to the Health and Disability Commissioner

HDC is an independent crown entity established under the Health and Disability Commissioner Act 1994 to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code places corresponding obligations on all providers of health and disability services, including organisational providers, such as RACFs, and individual providers, such as the staff who work at RACFs.

HDC promotes and protects the rights of consumers of health and disability services by:

- resolving complaints;
- improving quality and safety within the sector; and
- appropriately holding providers to account.

As such, HDC fulfils the critical role of independent watchdog for consumer rights within the sector.

Rights under the Code

1. The right to be treated with respect.
2. The right to freedom from discrimination, coercion, harassment and exploitation.
3. The right to dignity and independence.
4. The right to services of an appropriate standard.
5. The right to effective communication.
6. The right to be fully informed.
7. The right to make an informed choice and give informed consent.
8. The right to support.
9. Rights in respect of teaching or research.
10. The right to complain.

Anyone may make a complaint to HDC about a health or disability service that has been provided to a consumer. It is not uncommon for HDC to receive complaints from third parties, such as family members, friends, or other providers involved in the consumer's care, particularly in the aged care sector. The Commissioner may also commence an investigation on his own initiative, even without having received a complaint, if he considers it appropriate to do so.

The value of complaints for quality improvement

Every individual complaint represents an opportunity for learning. Both local and sector-wide changes result from the assessment and/or investigation of what went wrong in a particular case, and an analysis of how such events can be prevented in future.

While not all issues raised in these complaints are subsequently factually and/or clinically substantiated, consumers' complaints provide unique insights into aspects of care, such as compassion and dignity, that are not caught by other systems of healthcare monitoring and provide an additional perspective on consumers' experiences of the healthcare system and the issues about which they care most.

Considered together, complaints can become an even more powerful tool for widespread quality improvement. Understanding trends and patterns in the complaints received, and what occurred in the clinical interactions, allows for the identification of common issues and possible solutions.

In terms of RACFs, while individual complaints do not necessarily provide an overall measure of quality, an analysis of the issues commonly complained about can point to quality indicators that may require possible improvement or further investigation, as well as indicating the issues that are important to consumers and their families in terms of service quality.

4. The data used in this report

The data analysed in this report comes from the HDC's current complaints database. We extracted from that database all complaints made about RACFs between 1 January 2010 and 31 December 2014 (the HDC complaint data). We identified **502** such complaints.

Complaints to HDC often involve more than one provider, and multiple RACFs are sometimes involved in a single complaint. Additionally, in some cases, HDC will have received more than one complaint about the same RACF. The HDC complaint data is coded at the provider level. For each complaint received we conducted an analysis of the issues raised for each RACF complained about, calling each of these analyses a "case". Consequently, while the HDC complaint data includes only 502 complaints, it is made up of **514** cases.

The value in this data lies in our ability to analyse complaint trends over time. Therefore, it is intended that the data in this report will be updated regularly.

TRENDS IN COMPLAINTS ABOUT RESIDENTIAL AGED CARE FACILITIES

1. Number of complaints about residential aged care facilities

Introduction

This section looks at the number of complaints received by HDC about care provided by RACFs, and sets that number in context, both in terms of general complaint numbers and in terms of trends over time.

What does the HDC complaint data show?

Over the five-year study period, HDC received 502 complaints about care provided by RACFs. As reported below in Table 1, the number of complaints received about RACFs has remained relatively stable over time, with an average of 100 complaints received each year.

Table 1. Number of complaints received about care provided by RACFs, each year

2010	2011	2012	2013	2014
101	98	109	102	92

As shown below in Figure 1, the number of complaints received about RACFs has remained stable over time, despite the fact that the number of complaints received by HDC overall has shown a steady increase over time.

Figure 1. Number of complaints received each year

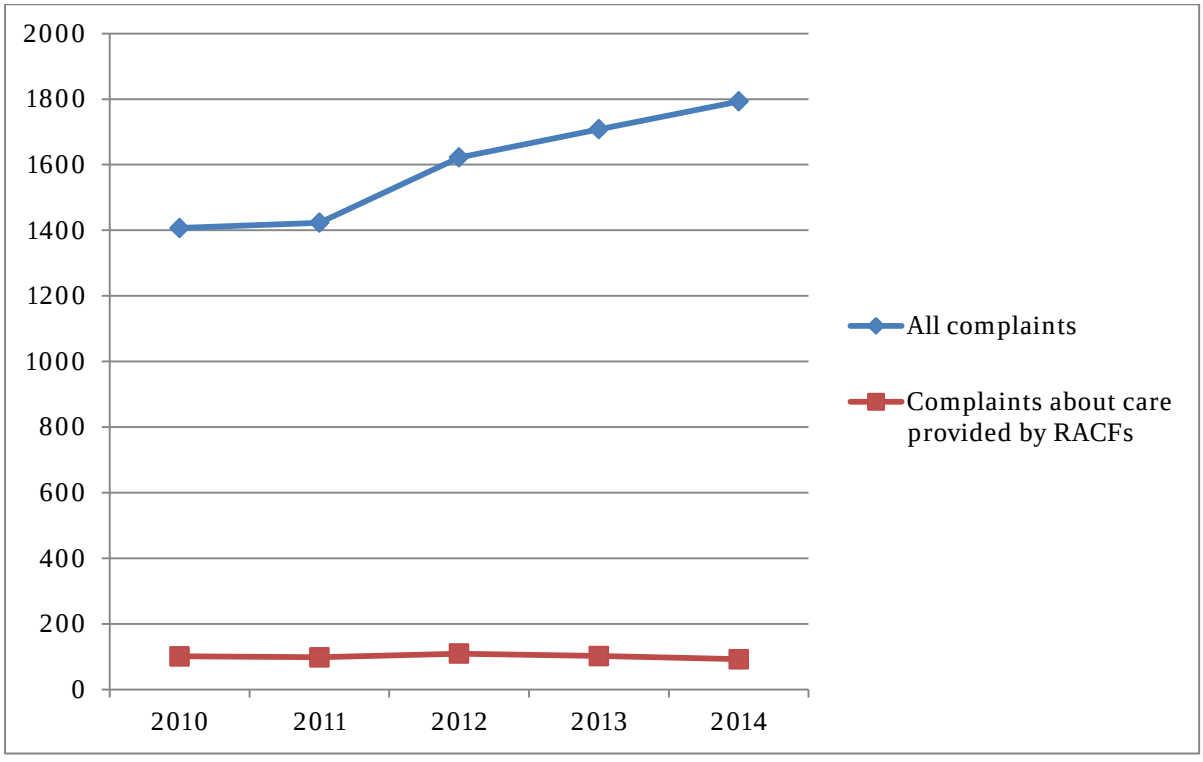


Table 2. Complaints about care provided by RACFs received each year, as a proportion of all complaints received

2010	2011	2012	2013	2014
7%	7%	7%	6%	5%

As reported above in Table 2, complaints about RACFs tend to make up around 7% of all complaints received by HDC each year, with this proportion showing a small decrease in recent years.

Why is the number of complaints received about RACFs not increasing?

The number of complaints about RACFs has remained relatively stable from year to year, despite the fact that the overall number of complaints received by HDC each year is increasing. The reason for this is unclear, but may be due to the fact that there are other avenues for consumers and their families to have their concerns about RACFs addressed. For example, complaints can be made directly to facility management, or to the DHB that funds the facility, or directly to HealthCERT, which can conduct inspections of the facility based on the issues raised within the complaint. Advocates from the Nationwide Advocacy Service also visit each New Zealand RACF at least once a year in order to ensure that advocates are accessible to residents. Advocates are able to assist residents to make and resolve complaints directly with the provider.

Table 3 shows the number of complaints received about care provided by RACFs as a proportion of the number of RACF beds available in New Zealand. As can be seen from the table, the number of complaints received is very low given the level of activity in the sector.

Table 3. Complaints about care provided by RACFs received each year as a proportion of the number of RACF beds available in New Zealand

	2011	2012	2013	2014
Number of complaints	98	109	102	92
Number of beds	36,273	36,109	36,876	37,398
Proportion	0.3%	0.3%	0.3%	0.2%

2. Issues complained about in relation to residential aged care facilities

Introduction

Little research has been conducted on complaints made about RACFs, either in New Zealand or internationally. In particular, very little is known about what is commonly complained about in relation to such facilities.

As outlined above, although some of the issues raised in this analysis may, on further analysis, have been found not to be clinically or factually substantiated, complaints are still valuable indicators of what consumers care most about and their subjective experience of healthcare services. Analysed together, complaints may point to areas worthy of further investigation as avenues for potential quality improvement.

This section of the report outlines the issues complained about in relation to RACFs as articulated to HDC by the complainant. In order to analyse these issues in a systematic way, a coding methodology was created that includes 63 types of issues raised in relation to the services provided by RACFs. These issues were then grouped into 14 over-arching categories according to the type of care they

represented. Each case was then coded for up to seven issues. This coding methodology is further explained and defined, with examples, in Appendix A.

What does the HDC complaint data show?

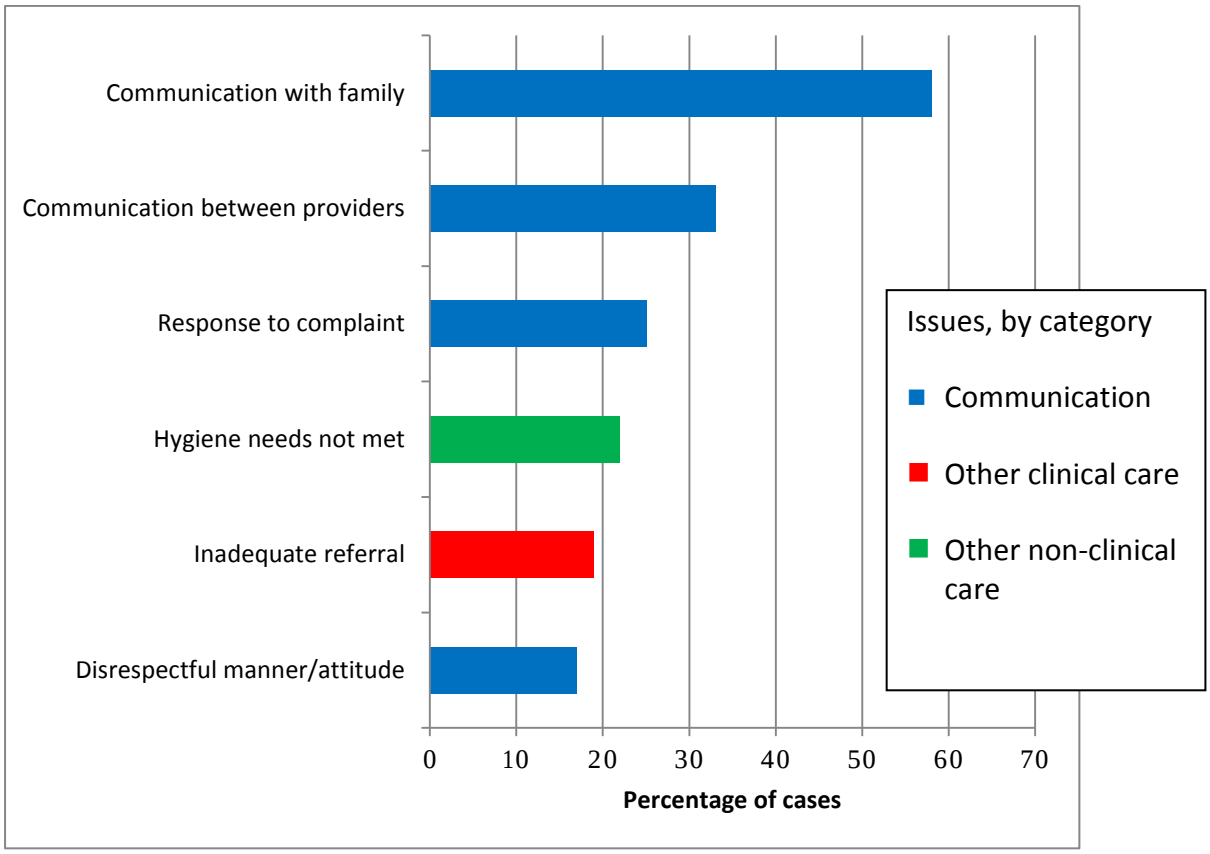
The complaint issues identified for each case are reported below in Table 4. For each case, up to seven complaint issues were identified. Note that each case was counted only once for each over-arching category.

Table 4. All issues complained about in relation to each case

All issues in complaints	Number of cases	Percentage
Communication	**448**	**87%**
Disrespectful manner/attitude	87	17%
Failure to communicate effectively with consumer	51	10%
Failure to communicate effectively with family	296	58%
Inadequate communication between providers	169	33%
Inadequate response to complaint	131	25%
Retaliation/discrimination as a result of a complaint	14	3%
Consent	**34**	**7%**
Consent not obtained/adequate	15	3%
Issue with EPOA/advance directive	23	4%
Documentation	**153**	**30%**
Failure to follow care plan	20	4%
Inadequate care plan	54	11%
Inadequate/inaccurate documentation	59	11%
Inadequate/inaccurate incident report	41	8%
Intentionally misleading/altered documentation	3	0.6%
Facility	**291**	**57%**
Cleanliness issue	38	7%
Failure to follow policies/procedures	26	5%
General safety issue for consumer in facility	55	11%
Inadequate infection control	9	2%
Inadequate policies/procedures	16	3%
Inadequate staffing levels	73	14%
Inadequate supervision/skills mix	84	16%
Issue with management of facility	41	8%
Issue with sharing facility with other consumers	26	5%
Issue with quality of aids/equipment	81	16%
Issue with quality of food	35	7%
Falls	**105**	**22%**
Inadequate post-fall assessment	65	13%
Inadequate risk assessment	10	2%
Inadequate risk management	66	13%
Restraint	**19**	**4%**
Inadequate assessment	5	1%
Inadequate management	14	3%
Inadequate monitoring	3	0.6%
Fluid/nutrition	**84**	**16%**
Inadequate fluid assessment	2	0.4%

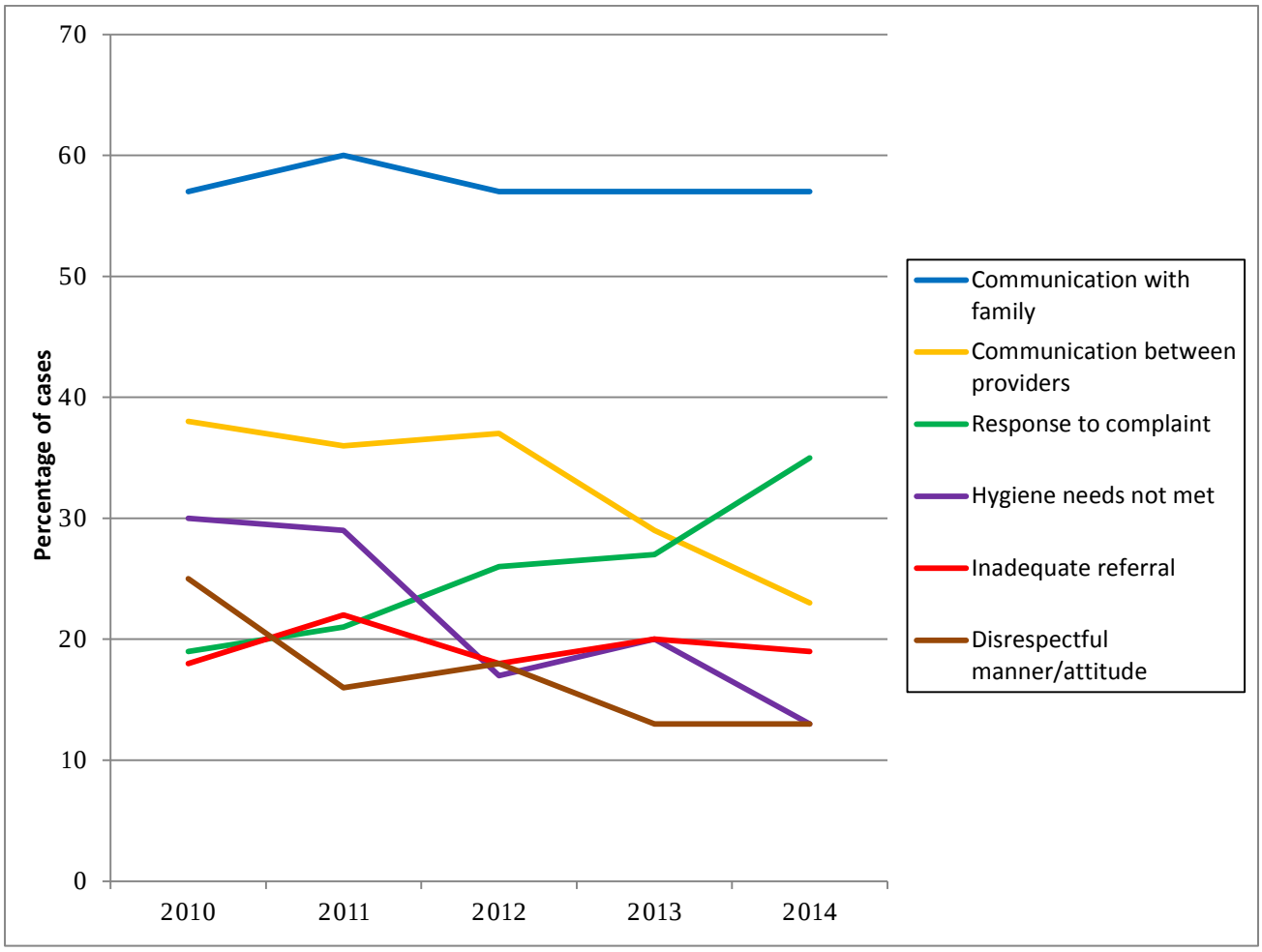
Inadequate fluid management	14	3%
Inadequate fluid monitoring	36	7%
Inadequate nutrition assessment	7	1%
Inadequate nutrition management	38	7%
Inadequate nutrition monitoring	23	4%
Incontinence	**38**	**7%**
Inadequate assessment	3	0.6%
Inadequate management	37	7%
Wound care	**76**	**15%**
Inadequate assessment	23	4%
Inadequate management	66	13%
Inadequate monitoring	18	4%
Deteriorating condition	**112**	**22%**
Inadequate assessment/recognition	53	10%
Inadequate management/treatment	53	10%
Inadequate monitoring	49	10%
Other clinical care	**171**	**33%**
Delayed/inadequate referral	100	19%
Inadequate discharge/transfer	31	6%
Inadequate needs/admission assessment	42	8%
Missed/delayed diagnosis	47	9%
Other non-clinical care	**215**	**42%**
Delay in attending	71	14%
Hygiene needs not met	112	22%
Inadequate supervision of residents	42	8%
Mishandling	53	10%
Personal privacy not respected	10	2%
Medication	**151**	**29%**
Administration error	30	6%
Inadequate pain management	79	15%
Missed/delayed administration	42	8%
Over-medicated	22	4%
Professional conduct	**57**	**11%**
Assault	9	2%
Disrespectful behaviour	10	2%
Financial exploitation	7	1%
Refusal to assist/attend	14	3%
Threatening/harassing behaviour	12	2%
Inappropriate collection/use/disclosure of information	9	2%
Other	3	

Figure 2. Common complaint issues



As shown in Table 4 and Figure 2, the most common complaint issue categories were communication (87%), facility (57%), and other non-clinical care (42%). The most common specific issues raised by complainants were "failure to communicate effectively with family" (58%), "inadequate communication between providers" (33%), "inadequate response to complaint by facility" (25%), "hygiene needs not met" (22%), "delayed/inadequate referral" (19%), and "disrespectful manner/attitude" (17%).

Figure 3. Common complaint issues, by year complaint received



As can be seen from Figure 3, communication issues have consistently been the most commonly complained about issues, with "failure to communicate effectively with family", "inadequate communication between providers" and "inadequate response to complaint by facility" being among the most common issues each year, over the last five years. Among these, "inadequate communication between providers" has shown a decrease in recent years, while "inadequate response to complaint" has increased. "Delayed/inadequate referral" has also consistently remained among the most complained about issues each year, being present in around 20% of cases each year. However, "hygiene needs not met" and "disrespectful manner/attitude" have both become less prominent in recent years.

Other issues have also shown changes in prominence over time, with "inadequate post-fall assessment", "mishandling of consumer" and "inadequate pain management" becoming more prominent in recent years, while wound management issues have decreased over time.

It must be noted that an analysis of the level of care provided by each facility in the HDC complaint data has not been undertaken. However, many of the clinical care issues discussed below, such as fluid/nutrition, deteriorating condition and pain management, will be more at issue for those facilities providing hospital-level or dementia care.

COMPLAINTS ABOUT SPECIFIC ASPECTS OF CARE

1. Communication

Manner/attitude

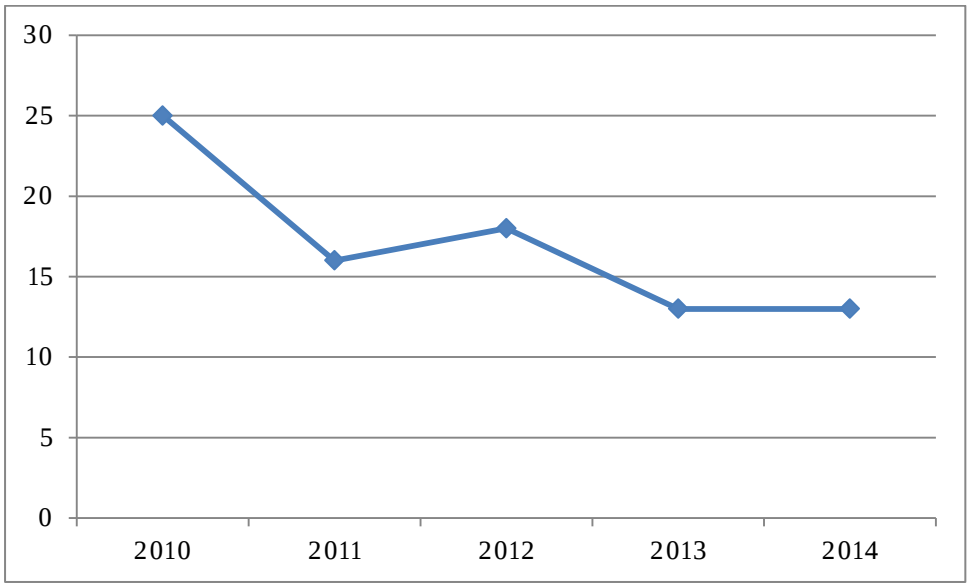
Introduction

The Standards under which RACFs operate require that all consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy and independence, and that service providers communicate effectively with residents and provide an environment conductive to effective communication. Additionally, all RACFs are required to comply with the Code, which states that all consumers have the right to be treated with respect.

What does the HDC complaint data show?

"Disrespectful manner/attitude" was a common issue in the HDC complaint data, with it being present in 17% of cases. However, as shown in Figure 4 below, this issue has become less prominent over time, with it decreasing from being present in 25% of cases in 2010 to being present in 13% of cases in 2014.

Figure 4. Percentage of cases where disrespectful manner/attitude was at issue, by year complaint received



Case study: Disrespectful manner/attitude

A man's family complained to HDC regarding the standard of care provided by an RACF, including the disrespectful manner of some of the staff members at the facility. The man's family were concerned that a nurse had made inappropriate comments around the changing of the man's colostomy bag, and that a lack of communication by facility staff meant that a family member was not able to be with the man when he died. A family member reported to HDC that she had met with the facility manager to discuss the family's concerns, but that she had felt that the facility manager had not been compassionate towards her.

The facility manager apologised to the man's family for giving the impression that she was not compassionate when she met with the family member. The facility manager further advised that it had become evident that the facility's policies and procedures were not followed when the man died, and that, consequently, disciplinary action had been taken against the staff member involved. A staff member admitted to making inappropriate comments around the changing of the man's colostomy bag.

The Deputy Commissioner considered that the actions taken by the facility in regard to the facility's policies and procedures not being followed by a staff member were appropriate. However, the Deputy Commissioner remained concerned about the comments made by the nurse around the changing of the man's colostomy bag. She considered that these comments indicated a lack of respect for the man and his family, and asked the facility to ensure that the nurse involved provided a written apology to the man's family for her comments and behaviour. The Deputy Commissioner also considered that facility staff should have communicated better with the man's family around the fact that the man was dying, and should have asked whether family members wanted to be with him when he died. The Deputy Commissioner asked the facility to discuss this situation with staff and to encourage them to be more open with families whose loved ones are dying, in order to ascertain their wishes for when the moment of passing occurs. These recommendations have been met by the facility.

Communication with family

"It is important to be communicating with families, keeping them up-to-date with changes in health status of loved ones (which is inevitable in Aged Care), informing them of incidents and accidents — after all they have entrusted the care of their loved ones to us" (11HDC00528).

Introduction

International research has found that family involvement is an important factor in residents' quality of life in RACFs.[31, 32] Due to their complex needs, residents' family members will often become their advocates. The Standards and the ARRC Services Agreement both emphasise the importance of family involvement. The ARRC Services Agreement requires facilities to "acknowledge the significance of each resident's family/whanau and chosen support networks". RACFs are required to, where appropriate, gain family input into the resident's care plan and notify them of any changes in the resident's condition or of any adverse events. There will, of course, be situations where residents, competent to make their own decisions, do not want their family involved in their care, and this should be respected.

Despite family involvement being acknowledged as being important to the care of residents, the role of the family has often been found, in practice, to be ambiguous and complex.[33]

What does the HDC complaint data show?

"Failure to communicate effectively with family" was the most common issue in the HDC complaint data, with this issue being present in 58% of cases. As shown in Figure 3 above, this issue has remained the most common complaint issue over time, with it being present in 57–60% of cases

each year. This finding is not unexpected, given that around 70% of complaints made about RACFs are made by family/friends of the consumer.

This is consistent with the literature in this area, which has found that staff–family relationships in RACFs are often complex.[33] Many of the complaints within this category related to family members complaining that staff had failed to keep them informed of a change in the resident's condition or of an adverse event experienced by the resident, such as a fall. There needs to be a shared understanding and agreement between residents, their family, and the facility about the circumstances in which the family will be contacted and the reasons for this. It is also important for each facility to have an open disclosure policy that sets out the expectations and procedures in regard to reporting all adverse, unplanned or untoward events to affected residents and their families. It is equally important that the expectations of this policy are communicated to, and adhered to by, all staff.

Many family members also expressed frustration that staff had not adhered to their requests or preferences in terms of the resident's care needs. Families also often felt as though their knowledge of the resident was not included in assessments of the resident's risk or in the formulation of risk management strategies. Guidelines around the assessment and management of high-risk clinical care areas for the elderly, such as falls and wound care, emphasise the importance of family involvement. Families often have valuable knowledge around residents' risk factors, management strategies and signs that their condition is changing. Family involvement in promoting risk management strategies can also often help to increase the success of these strategies.

Taken together, these findings emphasise the importance of following the Standards and ARRC Services Agreement and ensuring that, where appropriate, family involvement is encouraged, their input into care planning is sought, and they are kept well informed of any changes to the resident's condition or the occurrence of adverse events.

Case study: Failure to communicate effectively with family

Mrs A, an 87-year-old woman, was admitted to an RACF for short-term respite care following a total hip replacement. Mrs A had blisters on her heels and a reddening on her sacrum when she arrived at the facility. The DHB's district nursing service was responsible for caring for Mrs A's wounds.

The facility's admission assessment and documentation was incomplete, and Mrs A's care plan was not updated during her stay at the facility, despite her changing health status.

Mrs A's regular medications included lorazepam, used to treat anxiety. Three weeks after her admission to the facility, Mrs A's supply of lorazepam ran out on a Friday. The following day, Mrs A contacted her daughter in a distressed state. Her daughter telephoned the facility, but no action was taken to obtain a repeat prescription until the Monday.

During her admission, Mrs A had four falls. Mrs A's family were not contacted after the first three falls. When Mrs A fell for a fourth time, she hit her head on some drawers, causing a small cut. The GP was contacted and Mrs A's daughter was advised.

The next day the district nurse visited and found that Mrs A's legs were oedematous and fluid was oozing from them. Mrs A was sent to hospital, where she was referred for palliative care.

The Deputy Commissioner considered that there were several areas where the facility's communication with Mrs A's family had been inadequate, including around Mrs A's falls, her medication management, and her care plan. Mrs A's family was not informed of her second and third falls, despite these falls resulting in

skin tears. In addition, the facility was responsible for ensuring that Mrs A had access to her medications. However, there was no evidence that Mrs A's daughter was told that she and her family were responsible for arranging Mrs A's medication and transportation to medical appointments. Furthermore, it is clear that Mrs A's family were concerned about and involved in her welfare, but there is no evidence that the family were included in the development of Mrs A's care plan.

In relation to this case the Deputy Commissioner stated: "[I]t is important for staff at residential care facilities to talk to residents and their families about their expectations in regard to communication. There needs to be a shared understanding and agreement between the resident, his or her family, and the facility about the circumstances in which the family will be contacted, and the reason for this."

The Deputy Commissioner found that there were several areas in which the facility's care of Mrs A was substandard. By failing to ensure that Mrs A received the medications she was prescribed, the facility failed to provide services to Mrs A with appropriate care and skill, in breach of Right 4(1) of the Code. There were lapses in communication between staff and with Mrs A's family, and sub-standard documentation of Mrs A's condition and care. Accordingly, the facility was found in breach of Right 4(5) of the Code for failing to ensure that Mrs A received quality and continuity of services.

The facility advised HDC that it had taken a number of remedial actions in response to this complaint, including placing emphasis on following the facility's policies and procedures on family/whānau communication during accident and incident reporting. The Deputy Commissioner made a number of recommendations to the facility, including that it:

- apologise to Mrs A's family for its breaches of the Code;
- obtain an independent review of its policies and procedures;
- ensure that all staff receive adequate orientation and undergo regular training on its policies and procedures; and
- audit all care plans.

The recommendations have been met by the facility.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified inadequate communication between RACF staff and families include asking facilities to:

- review policies and procedures to ensure that staff adequately communicate with residents' family members regarding significant changes in health status;
- ensure that the facility's documentation regarding residents' Enduring Power of Attorney (EPOA) is up to date, and that they are aware of any status changes with the EPOA, such as activation;
- ask staff to document families' requests to ensure that they are carried out;
- include a timeframe for notifying appropriate people in the policy relating to abuse, neglect and discrimination, and incidents and near misses; and
- confirm introduction of a database system whereby family members can receive regular updates on their relatives' medical conditions and any changes to their general well-being.

Communication between providers

"Rest home owners have an organisational duty of care to provide a safe healthcare environment for its residents. This duty of care includes ensuring that staff work and communicate effectively together … the systems within which a team operate must function effectively in order to provide an appropriate standard of care to the residents" (11HDC00471).

Introduction

Staff within RACFs must operate in a multidisciplinary environment. Residents are cared for by a wide variety of professionals including general practitioners (GPs), allied health professionals (e.g., dieticians, speech language therapists, occupational therapists, physiotherapists, etc), specialist providers, registered nurses (RNs), enrolled nurses (ENs) and health care assistants (HCAs). Therefore, good communication and coordination of care between providers is crucial.

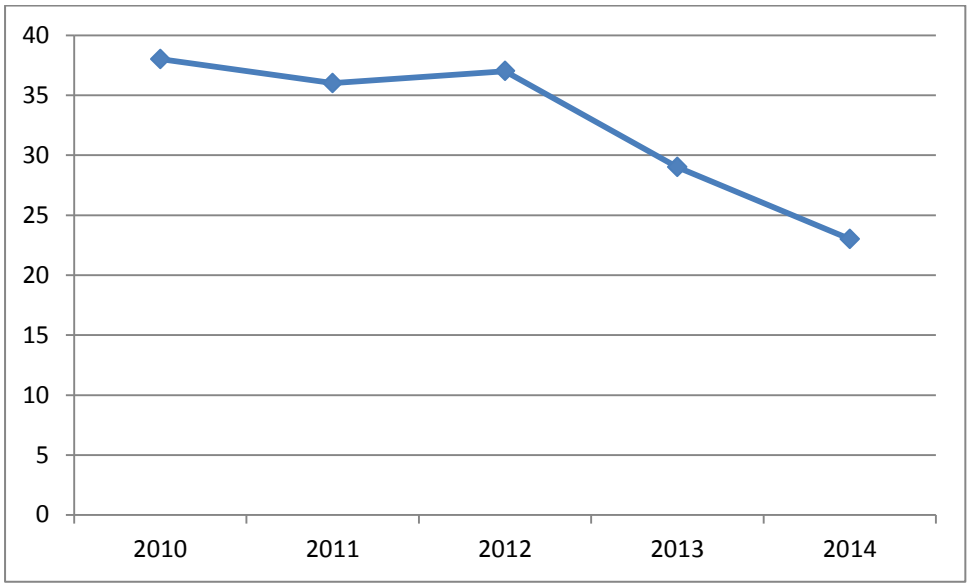
Within RACFs the exchange of information between staff on different shifts is essential to ensuring continuity of care.[34] The bulk of care within RACFs is carried out by HCAs under the supervision of a few RNs (and, in some cases, ENs). Communication between HCAs and RNs is important to ensure that RNs are appropriately supervising the care provided by HCAs, and because RNs rely on HCAs' more intimate knowledge of the residents to alert them to any issues and to ensure that residents' needs are being met. However, the few international studies that have been conducted into communication between providers within RACFs have found that cross-discipline communication is sometimes limited.[35]

In New Zealand, RACFs are dependent on GPs to provide medical assessment and intervention. Staff within RACFs will either contact the resident's own GP or a GP contracted to the facility if they assess that the resident needs medical care. The Ministry of Health also contracts GPs to provide at least three-monthly check-ups for all residents. However, a study of RNs working in New Zealand RACFs found that, due to a shortage of GPs and their high workloads, GPs were often unable to respond promptly when called.[36] GPs, in turn, are often reliant on RACF staff to alert them to any changes in residents' conditions or the need for intervention.

What does the HDC complaint data show?

Inadequate communication between providers is the second most commonly complained about issue in the HDC complaint data, being at issue in 33% of cases. This issue has consistently been among the most commonly complained about issues for each of the last five years. However, as can be seen from Figure 6 below, the proportion of cases in which it appears has decreased over time from 38% in 2010 to 23% in 2014.

Figure 3. Percentage of facilities for which "inadequate communication between providers" was at issue in a complaint, by year complaint received



Complaints about inadequate communication between providers most often related to communication between RACF staff and GPs. Complainants were often concerned that a GP had not been adequately informed of the resident's changing condition or of an adverse event, or that RACF staff had not adequately followed the GP's recommendations or treatment plan. Such complaints also arose in relation to concerns about the timeliness of GP intervention.

Best practice guidelines emphasise the importance of obtaining a GP review following changes in the consumer's condition to ensure that any clinical deterioration is assessed early on, diagnoses made quickly, and treatment given promptly. GPs are often reliant on facility staff to notify them of changes in residents' conditions. It is important that facilities have robust policies and procedures around when a resident's care needs to be escalated for GP review and what information needs to be communicated to the GP. Facilities also need good systems around the scheduling of prompt GP patient appointments and follow-up, for example, having a designated GP who holds weekly clinics within a facility is a service model that has shown some success within RACFs.

The ARRC Services Agreement also requires facilities to ensure that GPs enter findings, and any treatment given to, or ordered for, the resident, into the relevant clinical records maintained on site at the time of the GP's attendance. This is important for ensuring that the GP's recommendations and treatment plans are communicated to, and followed by, facility staff.

This complaint issue was also often in relation to communication issues between staff within RACFs. Complainants were concerned that important clinical information had not been adequately passed on from HCAs to RNs. This is consistent with research within this area, which has found that RNs report having little time to supervise HCAs, while HCAs report feeling as though their knowledge is undervalued by RNs.[35–37] Australian literature has also identified that communication within facilities can be made more difficult by the multiple and complex sources of information used to manage residents, with not enough documented information being available at the point of care.[38] Clinical records should be integrated. Fragmentation of documentation and multiple means of communication compromises continuity of care. Facilities should have communication systems that ensure that resident information is integrated, comprehensive and easily available to staff.

Case study: Inadequate communication between providers

Mrs B, a resident at an RACF, developed a stomach bug and experienced vomiting and diarrhoea. A dipstick urinalysis test indicated that Mrs B was suffering from a urinary tract infection (UTI). However, a urine sample was not obtained to confirm this. Mrs B was started on a course of antibiotics to treat the UTI. However, not all health providers involved in her care were aware of her diagnosis or treatment. The antibiotic prescription was inaccurately documented, resulting in Mrs B not receiving the full course of the medication.

In the days that followed, Mrs B had five falls and continued to deteriorate. Steps were not taken to investigate the cause of her continuing deterioration. Importantly, no further urine test was obtained. Incident forms were filled out in relation to her falls, but they contained incorrect information and were not appropriately signed off, and were not acted upon. Mrs B's family were not contacted during this period.

Five days after she was diagnosed with a UTI, staff advised one another that Mrs B was for palliative care. No decision regarding palliative care had been made or discussed with Mrs B, her family, or the necessary health providers. When Mrs B's family arrived at the facility, they were advised that Mrs B was for "comfort cares". The following day, at the request of Mrs B's family, Mrs B was admitted to hospital, where she was diagnosed with urisepsis caused by her UTI. Sadly, Mrs B passed away a short time later.

The Deputy Commissioner was critical of the fact that staff at the facility did not adequately communicate Mrs B's deteriorating health condition to one another, or document these communications. Mrs B's progress notes were not filled in consistently, and the information that was recorded was deficient. Additionally, discussions at shift handover lacked structure and occurred on an ad hoc basis. This resulted in important information regarding Mrs B's care and treatment not being passed on.

There were also miscommunications between staff regarding whether Mrs B was for palliative care. HDC's expert clinical advisor stated that this decision should not have been assumed, it should have been a formal discussion between nursing staff, medical staff and family, and interventions and ongoing cares should have been documented.

The Deputy Commissioner also considered that the nursing staff's communication with the GP was inadequate. It would have been appropriate for nursing staff to have directly notified the GP that Mrs B had a UTI and was taking antibiotics to ensure that appropriate action was taken over the coming week. However, there is no evidence that this occurred. Furthermore, although it was recorded in the progress notes that the GP had requested that Mrs B be seen by a dietician, and that blood tests and a urine specimen be taken, these requests were not actioned by nursing staff.

In relation to this case, HDC's expert advisor commented:

> "The standard of care deteriorated when this communication broke down — family not notified in change of health status, instructions from doctors not passed on or documented and staff not given clear instructions as to the care that was expected of them."

The Deputy Commissioner's report identified a number of failures in the care provided to Mrs B, including: the poor communication between healthcare staff, and between staff and Mrs B's family; inadequate documentation of the care provided; and the delayed and inadequate treatment of Mrs A's UTI. The Deputy Commissioner found a number of nursing staff at the facility in breach of the Code for these deficiencies.

The Deputy Commissioner also considered that the facility had failed to ensure that its policies and procedures were appropriately implemented by clinical and care staff at the facility, leading to a breakdown in communication between staff. Accordingly, it was found that the facility failed to provide Mrs B with appropriate care and treatment, in breach of Right 4(1) of the Code, and that systemic failure in the facility had serious negative consequences for the continuity of care provided to Mrs B, in breach of Right 4(5) of the Code.

The Deputy Commissioner made a number of recommendations to the facility, including that it:

- apologise to Mrs B's family for its breaches of the Code;
- provide HDC with evidence that its documentation system had been consolidated, in order to ensure improved communication between staff, and report on its implementation at the facility;
- provide training to staff about current documentation policies, and the importance of having a comprehensive and up-to-date record of a resident's care and needs;
- conduct an audit of patient records to assess compliance with documentation policies and professional standards; and
- use its audit report as a basis for staff training at the facility, focusing particularly on the breaches of the Code identified.

The recommendations have been met by the facility.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in communication between providers include asking facilities to:

- provide training to RNs to help them become more assertive when discussing their concerns about a consumer's condition with the contracted GP or after-hours provider;
- develop a policy relating to the process for escalating a concern to the GP, including in-house training on the policy;
- remind nursing staff of the importance of keeping GPs fully informed about a patient's condition and any family concerns — particularly patients who have limited communication and may not be able to communicate adequately;
- introduce procedures or guidelines for staff to follow in the event they are unable to reach the on-call GP in a medical emergency;
- provide training to RNs on the principles of delegation — this should be guided by the Nursing Council of New Zealand's document "Delegation of care by a registered nurse to a healthcare assistant"; and
- provide HDC with details of changes made to ensure appropriate handover and safe transfer of care from the night staff team to the day staff team.

Documentation

> *"The clear and accurate documentation of a resident's condition and the care provided is not optional. It is a means by which relevant information is shared between those providing care and treatment, and is a key component of effective teamwork" (12HDC01229).*

Introduction

Good clinical records are integral to care provision and continuity of care. They demonstrate the reasoning behind a diagnosis, set out key information upon which decisions about care are based, and ensure that other staff members know what decisions have previously been made and what care has been provided.

The ARRC Services Agreement requires all facilities to ensure that all HCAs, RNs and ENs maintain a written record of progress for each resident and to ensure that each resident has a care plan that documents his or her current abilities, identified personal care and health care needs, and personal

preferences. The Standards require that consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

It should be noted here that use of the Comprehensive Clinical Assessment (interRAI) tool is now mandatory in all New Zealand RACFs. This may help to ameliorate many of the issues around care planning discussed below.

What does the HDC complaint data show?

In 30% of cases in the HDC complaint data inadequate documentation was noted as an issue, and this was most often in relation to residents' progress notes and care plans. In RACF complaints that have undergone a formal investigation, HDC has frequently found that inadequate documentation and care plans have contributed to care deficiencies.

Continuity in service delivery relies on a verbal and written handover between shifts that identifies care requirements, as well as daily entries in residents' progress notes. Progress notes record the day-to-day care provided, the status of the resident, evaluations of that care, and any changes to care that may be required. When progress notes are not frequently or adequately completed, RNs are not alerted to issues that require their attention, and staff are not given direction as to the required care for a resident. A facility's documentation policies need to outline the expectations on staff around the importance of keeping accurate, concise and up-to-date progress notes — including how frequently these need to be completed, the information that should be recorded, and the importance of reviewing previously made notes. It is equally important that this policy is communicated to all staff, and that there are systems in place to monitor staff adherence to these policies.

In 11% of cases in the HDC complaint data, the complainant identified care planning as an issue. As can be seen in the next section, inadequate care plans tended to be a frequent issue in complaints regarding clinical care areas. Care plans are fundamental tools that enable all staff to provide care that is consistent with a resident's needs. The care plan states the resident's actual and/or potential problems/deficits, sets goals for rectifying these, and details required interventions. In RACF settings, where care is provided by both registered and non-registered staff, a care planning process that involves a comprehensive assessment, plan, implementation and evaluation is essential to continuity of care. As the Commissioner has stated:

> *"Effective care planning is fundamental to the provision of good residential care … A documented care plan enables multiple staff to ensure that the provision of care is consistent with a resident's needs … It is the proper documentation of this process that ensures continuity of care" (13HDC00196).*

A nursing assessment is the foundation on which a comprehensive care plan is built. Appropriate risk assessment tools should be used, and assessments should utilise information from the resident, his or her family, and other healthcare services. DHBs now require all RACFs to use the interRAI tool to carry out these assessments. Policies within facilities should reflect the need for care plans to be based on a comprehensive nursing assessment (interRAI), and facilities need to monitor care plans to ensure that RNs are complying with this policy.

In order to ensure that a resident's changing care needs are communicated to all staff, the care plan needs to be kept up to date. The ARRC Services Agreement requires that residents' care plans are updated at least six monthly or when their condition changes, and that residents' short-term needs (such as wound care or infection), together with planned interventions, are documented either by amending the care plan, or as a separate short-term care plan. It is important that facilities have

systems in place to monitor the use of short-term care plans and ensure that care plans are up to date and reflect the resident's current needs.

To ensure continuity of care across the healthcare team, instructions to non-registered staff in care plans must be clear, reflect residents' needs, and be easily accessible by all staff. However, it is just as crucial to ensure that all staff are implementing the instructions for residents' care as set out in these plans. It is important that facilities have robust systems in place that ensure that all staff are aware of the importance of care plans for continuity of care, that they find care plans easy to access and follow, and that they are implementing them consistently.

As mentioned above, the fact that use of the interRAI tool in RACFs is now mandatory may assist to resolve many of these issues around care planning. InterRAI assessments are a standardised assessment tool that provides a comprehensive clinical assessment of a person's medical, rehabilitation and support needs and abilities. This information allows nurses to write tailor-made care plans for each resident, and to monitor the resident's progress to see which interventions have been of benefit and what else needs to be done. The standardised language and definitions allow these instruments to be used in different care settings, and for assessments to follow residents on their continuum of care.[39]

Documentation advice is available to facilities through the New Zealand Aged Care Association and DHBs.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in documentation include asking facilities to:

- review their documentation policies to ensure they are in line with professional standards;
- audit patient records to assess staff compliance with documentation policies and professional standards;
- provide training to staff about current documentation policies, and the importance of having comprehensive and up-to-date records of a resident's care and needs;
- provide evidence that the facility has consolidated its documentation system;
- provide training to staff about the importance of accurate documentation regarding the administration of medication; and
- conduct an audit of care progress notes to ensure that entries are being made at least once every 24 hours, as required by the facility's policy.

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in care planning include asking facilities to:

- advise HDC of the systems in place to monitor and audit care planning on a regular basis;
- provide HDC with evidence of a formal process for making sure that caregivers are aware of, and comply with, resident care plans;
- develop a policy regarding the effective use of short-term care plans;
- provide evidence that caregivers and nursing staff have undertaken further education on patient care planning so as to meet relevant nursing standards; and
- remind staff of the need to ensure that care plans are complied with at all times.

Complaints management

> *"Handled with due care and consideration, complaints can provide opportunities for learning and improvement. Handled badly, they can inflame a situation and increase mistrust. Dealing with complaints effectively and meaningfully is an essential part of providing a quality health service" (09HDC01040).*

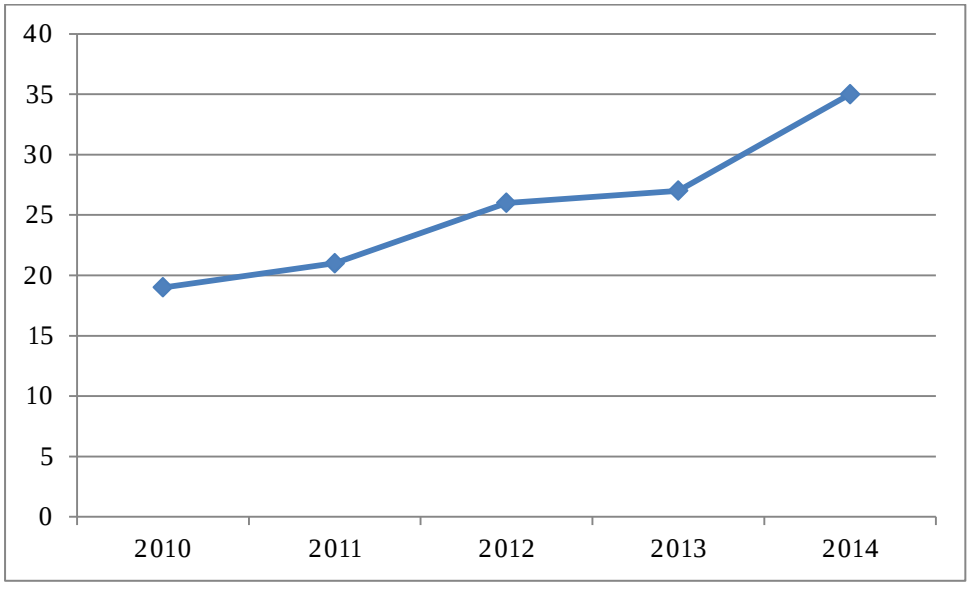
Introduction

The Standards and the ARRC Services Agreement require RACFs to uphold Right 10 of the Code. This states that every consumer has the right to complain about a provider in any form appropriate to the consumer, and that every provider must facilitate the fair, simple, speedy and efficient resolution of complaints. Additionally, the ARRC Services Agreement requires RACFs to have robust complaints management policies and procedures.

What does the HDC complaint data show?

"Inadequate response to complaint by facility" was a common issue in the HDC complaint data, with this issue being present in 25% of cases. This is consistent with findings about other large group providers, for example this issue is also present in around a quarter of all complaints to HDC about DHBs. As shown in Figure 5 below, "inadequate response to complaint by facility" has become more prominent over time, with it increasing from being present in 19% of cases in 2010 to 35% of cases in 2014.

Figure 5. Percentage of cases where inadequate response to complaint was at issue, by year complaint received



In these cases, complainants reported that they had first complained to the facility and had been dissatisfied with its response. These complaints may represent issues that could have been resolved by the facility, without the need for escalation to HDC. As complaint volumes continue to rise, HDC encourages all providers to consider how best to equip their staff to manage complaints well internally. Complainants are often most satisfied when complaints are resolved early and at the point of service.

The starting point for a good complaints management system is being open to complaints. This means having a clear, visible and accessible complaints process. Facilities should have a culture that

welcomes complaints and encourages staff to respond to complaints in a positive and proactive way. The issue of inadequate response to a complaint should be viewed in tandem with a failure to communicate effectively with family, as many of the complainants in this dataset were family members complaining on behalf of their elderly relatives. These complainants often reported that they had felt dismissed or unheard by the facility. As noted in the international literature, the use of positive communication strategies by staff, and making family feel heard and valued, is important to the formation of constructive relationships.[40–42]

It is important to help consumers to overcome barriers to complaints, including fear of negative impact on service availability. It should be noted that in 3% of cases, the complainant raised concerns about experiencing retaliation and/or discrimination as a result of their complaint.

Case study: Inadequate response to complaint by facility

A man's family complained about a number of aspects of the care provided to the man by an RACF. The man's family reported that initially they had complained to the facility. However, the man's family had disagreed with the facility's version of events, and they were concerned that the facility had refused to provide them with details of the changes that had been made as a result of their complaint. The family felt as though their complaint had been "brushed under the carpet" by the facility.

The facility advised HDC that it had provided an apology to the man's family, both in writing and in person, for the deficiencies in the man's care. However, the facility did acknowledge that the family may have been unaware of all of the remedial steps the facility had taken in response to the complaint. The facility reported that since these events it had made a number of improvements to its complaints procedure.

The Deputy Commissioner considered that the actions taken as a result of the complaint were not adequately communicated to the man's family by the facility. The Deputy Commissioner commented that by not communicating the remedial steps taken, it was unsurprising that the family were left with the impression that their complaint had been swept under the carpet. However, the Deputy Commissioner considered that the changes made by the facility to its complaints procedure were appropriate, and she trusted that, in future, the facility would be clearer about explaining what action had been taken in response to a complaint.

HDC recommendations

There is no one way as to how a facility should respond to a complaint — the response will depend on the circumstances of the case and the consumer's needs. But there are some factors that facilities should consider having in place, as identified in recommendations made by HDC:

- Encourage staff to respond promptly and appropriately to expressions of dissatisfaction.
- Identify what the consumer is hoping to achieve by making a complaint.
- Identify who provided the service to the consumer, and who is in charge of that service — those staff should be made aware that a complaint has been made and, where appropriate, be actively involved in responding to the complaint.
- Consider what resolution process would be the most effective is achieving resolution for this particular complainant, for example, consider whether a resolution meeting is appropriate or whether a written response should be given.
- Record and acknowledge the complaint and ensure that systems allow learnings from complaints to be captured.

There are many resources available to support organisations in managing complaints. HDC has a variety of resources available at www.hdc.org.nz — including complaints management guides for primary care and DHBs (much of which will be relevant to RACFs) and a fact sheet on providers' obligations under Right 10 of the Code. The Health and Disability Advocacy Service, provided by the National Advocacy Trust, can be a valuable resource for complaints resolution.

2. Hygiene

> *"Leaving Mrs A for an unreasonable length of time soiled or wet from urine could have compromised her health and showed a lack of respect for Mrs A's dignity … In my view this is unacceptable" (11HDC00883).*

Introduction

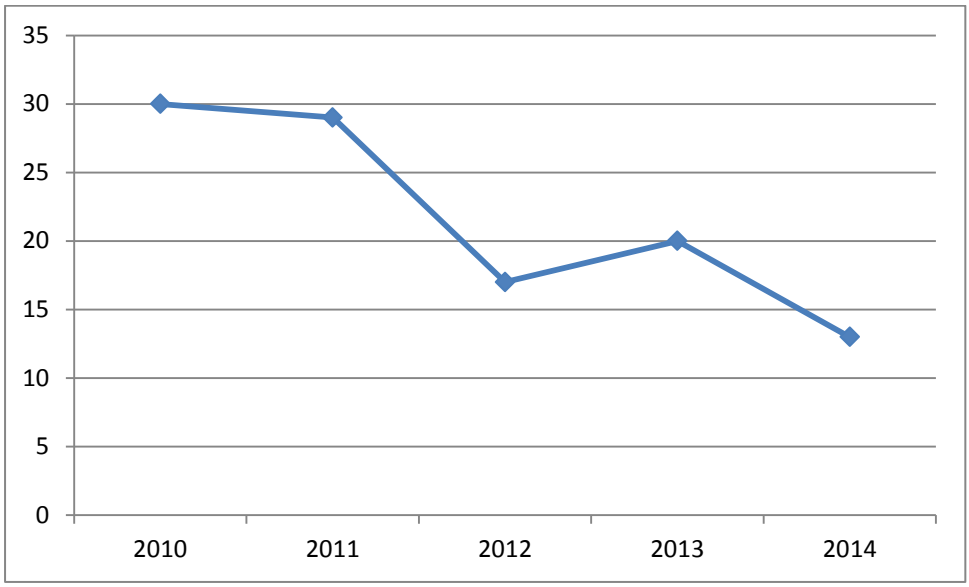
The increasing dependency of residents in RACFs means that care time is frequently taken up with attending to residents' personal hygiene needs. Around 47% of residents in New Zealand RACFs are dependent on care for the activities of daily living,[19] which includes a number of personal hygiene needs, such as assistance with showering, dressing, grooming and toileting. Studies show that 30–45% of an HCA's workday is spent on these activities.[43–45] In addition, an estimated 60% of residents in New Zealand RACFs are incontinent, which increases the time that must be spent on hygiene assistance.[17, 19, 46]

The ARRC Services Agreement requires that all residents be provided with assistance with the activities of daily living and personal care as determined by their individual needs. Each facility is also required to have policies related to personal grooming and personal hygiene.

What does the HDC complaint data show?

Complaints alleging that a resident's hygiene needs had not been met by the facility are common, with this being at issue in 22% of cases. As can be seen in Figure 7 this issue has become less prominent over time, with it decreasing from being present in 30% of cases in 2010, to being present in only 13% of cases in 2014.

Figure 4. Proportion of cases where hygiene needs not met was at issue, by year complaint received



These complaints were most often in relation to complainants alleging that a resident had not been showered often enough by staff, or that the resident's toileting needs had not been adequately attended to. Complainants were also often concerned about personal grooming tasks not being carried out often enough by staff, such as residents not being provided with shaving or haircare assistance, or a resident not being dressed appropriately.

The fact that many residents within RACFs require personal hygiene assistance, and the fact that the effects of this assistance not being carried out are very visible to family members and the residents themselves, may explain why this is such a common complaint issue. It also indicates that there may be a mismatch of expectations around hygiene care between residents' families and facility staff. It may, therefore, be important for staff to have a conversation early on with residents and their families around their expectations for hygiene care and what is possible within the context of the facility.

The organisation's expectations around the management of residents' incontinence should also be made very clear to staff. The Standards require consumers to be treated with respect and receive services that have regard for their dignity. Leaving consumers in a soiled state can seriously compromise their dignity. Additionally, it has been found that contact between skin and urine puts residents at a greater risk for wound development. However, the finding that this complaint issue is decreasing markedly over time, despite an increase in residents with incontinence issues within New Zealand RACFs,[8] is encouraging.

Case study: Hygiene needs not met

A woman's family complained to HDC regarding the standard of care provided by an RACF, particularly in respect to her personal cares. The woman required assistance with the activities of daily living, including showering. The complainant alleged that the woman's showers were infrequent, and that any washing that was done was not thorough enough. The facility advised HDC that the woman would often refuse showers.

HDC's expert clinical advisor advised that although the woman's initial care plan detailed her preference to have three showers per week, her latest long-term care plan did not detail her shower preferences. The expert advisor confirmed that the woman would sometimes go six days without a shower, although it was noted that this may have been compounded by the woman's occasional refusal to shower. The expert advisor further noted that the absence of shower details in the care plan may have allowed staff to choose whether to offer the woman a shower on particular days.

The Deputy Commissioner recommended that the facility record residents' showering and bathing preferences in their long-term care plans, including the residents' preferences regarding shower frequency. If a resident refuses to shower on a particular day, staff should record any planned follow-up action in the progress notes. The facility has met this recommendation, and further stated that, due to this complaint, staff would be undertaking training on informed consent and refusal of care.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in hygiene care include asking facilities to:

- ensure that non-registered carers are more aware of their responsibilities to their patients, using the complaint as an anonymised example;
- record residents' shower and bathing preferences, including shower frequency and preferred days, in long-term care plans — if a resident refuses to shower on particular day, planned follow-up action should be recorded in the progress notes;
- organise education on bowel health; and
- remind care staff of the need to maintain patients' dignity at all times through the provision of daily care.

3. Fluid/nutrition

"Monitoring and ensuring adequate food and fluid intake is part of what is required to meet expected standards of care" (11HDC00471).

Introduction

Age-related changes to functioning mean that older people are at a higher risk for malnutrition and dehydration than the general population, with both these issues being reported to be prevalent in RACFs. A study of New Zealand RACFs found that 15% of residents had a high risk of becoming malnourished, and 24% of residents were actually malnourished.[19] International studies have found that 32–96% of residents in RACFs have an inadequate fluid intake.[47, 48] Malnutrition and dehydration are associated with a number of poor clinical outcomes for older people including increased risk of infection, confusion, falls, pressure ulcer development, reduced mobility and increased mortality and morbidity.[49] However, it must be noted that while the prevention of malnutrition and dehydration are important clinical issues for RACFs, some conditions in the elderly

(such as dementia) irreversibly affect nutrition. Additionally, dehydration and malnutrition often accompany the dying process, and it may not always be appropriate to treat these symptoms aggressively in end-of-life care.

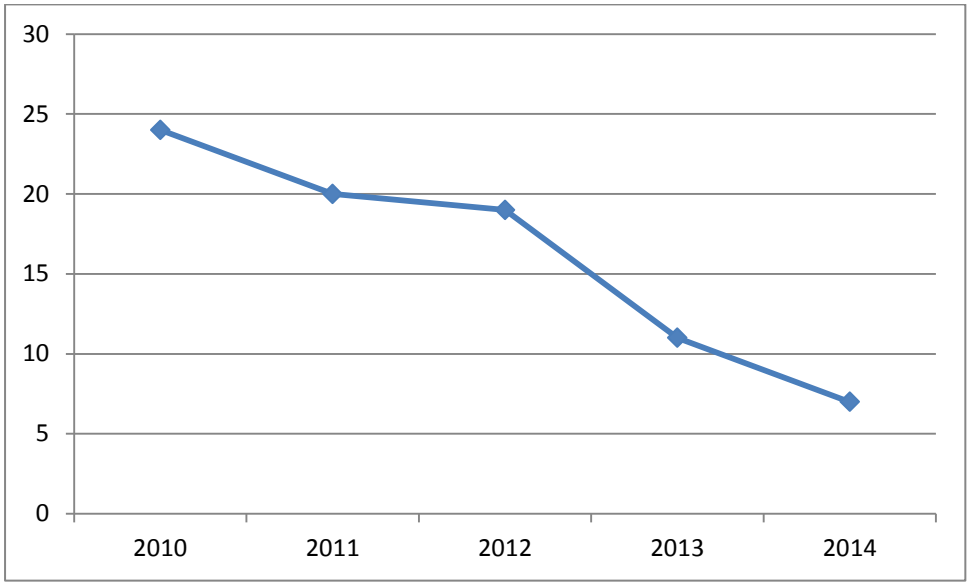
In New Zealand, the Standards require all RACFs to meet residents' individual food and fluid needs. New Zealand best practice guidelines in this area emphasise the importance of screening all residents for their risk of malnutrition and dehydration on admission to the facility and routinely, and when there is a change in the resident's condition, thereafter. When concerns are raised or unintentional weight loss or dehydration occurs, expected management includes monitoring through the use of fluid balance charts and food intake charts.[50–52]

Coordination and cooperation with allied health professionals is important to the management of residents' nutrition and fluid needs, with dieticians and speech language therapists being particularly important. It is also important that a resident's GP is notified when nursing staff note a trend of poor food/fluid intake and/or unintentional weight loss/dehydration, so that they can assess the resident for any underlying causes.[50, 52]

What does the HDC complaint data show?

Fluid/nutrition was at issue for 16% of cases in the HDC complaint data. No one fluid/nutrition issue received a large number of complaints. As can be seen below in Figure 8, the proportion of cases for which a fluid/nutrition related issue was complained about has decreased over time from 24% of cases in 2010 to 7% in 2014.

Figure 8. Percentage of cases for which a fluid/nutrition related issue was complained about, by year complaint received



Upon further analysis of cases involving fluid/nutrition issues, it was found that for 29% of these cases HDC's expert clinical advisor considered that there had been a failure to start or accurately complete a fluid balance chart. Assisting a resident to maintain an adequate oral intake is necessary for the avoidance of dehydration. Therefore, monitoring a resident's fluid intake is an important step in preventing dehydration and ensuring that the resident's hydration goals are being met. New Zealand best practice guidelines recommend that a fluid balance chart should be started for any

resident showing signs of dehydration, or for those who are at high risk of dehydration.[52] International research in this area, however, has found that fluid balance recording in RACFs is often inadequate or inaccurate because of staff shortages, lack of training, or lack of time.[53]

An important step in ensuring that fluid balances are adequately completed by staff is to ensure that these charts are a part of the resident's care plan. However, in 19% of cases involving fluid/nutrition issues, the complainant was also concerned about the adequacy of the resident's care plan. This often related to the failure to start a short-term care plan adequately, or revise the resident's current care plan in response to a change in the risk for malnutrition or dehydration. Fluid balance charts are an important part of any care plan used to manage a resident's increased risk of dehydration, and care plans should communicate to all staff the requirements around the completion of these charts.

A common issue seen on assessment of complaints around fluid monitoring was that, although a fluid balance chart had been started appropriately, the resident's fluid intake and output were not consistently recorded by staff. Without consistent recording it is impossible to evaluate any deterioration in the consumer's fluid intake or whether fluid management interventions are effective. Whether or not a chart is completed adequately is often reliant on the care plan alerting all staff to the fact that a chart has been started, and clearly communicating the need to consistently record the resident's fluid intake and output in the chart. It is also reliant on facilities having effective documentation systems and an organisational culture where the importance of adhering to care plans and completing comprehensive documentation and recordings is emphasised.

In 36% of cases involving fluid/nutrition issues, the complainant was also concerned about communication between the providers involved in the resident's care. Managing a resident's risk for malnutrition and dehydration requires a multidisciplinary team approach, with allied health professionals and GPs having important roles to play.[51] Within facilities, RNs are responsible for assessing, monitoring and managing residents' nutrition and fluid needs. However, HCAs and kitchen staff are often best placed to note any changes in a resident's status, and are also often those responsible for encouraging residents' nutrition and fluid intake. Therefore, good communication between all staff in facilities is necessary to the management of these issues.[52]

Waitemata DHB has guidelines for both RNs and HCAs around fluid and nutrition assessment, monitoring and management.

Case study: Fluid/nutrition

Mrs A, a 95-year-old woman, was admitted to an RACF. Mrs A had a history of swallowing difficulties and weight loss, and she required a puréed diet. A month after admission, Mrs A's weight was recorded at 38.6kg.

Nursing assessments were completed at the time of Mrs A's admission. However, no initial short-term care plan was completed, and her long-term care plan was not completed until seven months after her admission.

Nine months after her admission, it was noted that Mrs A might be dehydrated. Staff were advised to push fluids and to commence a fluid balance chart. A few weeks later, her GP noted that Mrs A was very underweight and recommended that she have a nutritional supplement. Mrs A was started on a nutritional supplement, but she continued to lose weight.

Just over a year after her admission, Mrs A weighed 35.55kg. This was a loss of 10.8% over the previous six months. Although staff often observed that Mrs A was reluctant to eat, little was done to investigate or

address her ongoing weight loss. At this time Mrs A's care plan was updated. It was noted that Mrs A had been refusing to eat and that she appeared to prefer the assistance of particular staff. However, the care plan did not refer to Mrs A's puréed diet, her nutritional supplement, the fluid balance chart, or her ongoing weight loss.

Weight checks the following month indicated that Mrs A was continuing to lose weight. Mrs A was due to be seen for her monthly GP review, but because the GP did not have time to see all of the patients he was scheduled to visit that day, Mrs A's review was postponed until the GP's next scheduled visit. Before this next visit could occur, Mrs A's condition deteriorated and she was admitted to hospital. Mrs A was diagnosed with, and treated for, community acquired pneumonia with secondary aspiration pneumonia and silent aspiration. Sadly, Mrs A died a short time later.

The Deputy Commissioner found that Mrs A's care planning was inadequate. The fact that Mrs A was without a long-term care plan for such an extended period suggests that the facility did not have in place an effective system to monitor the completion of care plans. Additionally, the care plans that were completed did not include specific information regarding Mrs A's care and support needs to guide the staff caring for her.

The Deputy Commissioner was also critical of the facility's management of Mrs A's weight loss and hydration status. Unintentional and unexplained weight loss of the magnitude Mrs A experienced is concerning for any resident; it should have prompted further investigation or considerations for a resident with a starting weight as low as Mrs A had. However, there is little evidence that staff recognised the significance of Mrs A's continuing weight loss. The reasons for Mrs A's reluctance to eat were not investigated adequately, the possibility of seeking input from a dietician or speech language therapist regarding her eating difficulties was not considered, and there is no evidence that her continuing weight loss was brought to the attention of the GP.

When it was identified that Mrs A was dehydrated, a fluid chart was commenced. However, the fluid intake recordings were incomplete, there was no reference in the care plan to fluid charts, there was no evidence that the charts were evaluated, and there was no system to ensure that self-administered fluids were recorded. Accordingly, the fluid balance charts that were completed were of limited value.

The Deputy Commissioner considered that, although the facility had policies in place for care planning and weight loss management, it did not have a staff culture and adequate systems to ensure that staff adhered to those policies. In addition, its system for the monitoring and recording of fluids was not followed consistently, and was, in itself, flawed. In these circumstances, the Deputy Commissioner found that the facility failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner made a number of recommendations to the facility, including that it:

- apologise to Mrs A's family for its breaches of the Code;
- undertake an audit of all care plans;
- advise HDC of the systems in place to monitor and audit care planning on an ongoing basis;
- advise HDC of the procedures in place to ensure accurate monitoring of fluid intake for those residents who require this; and
- undertake an audit of compliance with the updated nutritional policy.

The recommendations have been met by the facility.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in fluid or nutrition assessment/monitoring/management include asking facilities to:

- review their policies and procedures around the monitoring of fluid intake and hydration of residents;
- conduct an audit of progress notes to ensure entries are being made at least every 24 hours;
- review procedures in place to ensure accurate monitoring of fluid intake for residents who require this;
- introduce a separate weight chart/graph for each resident;
- develop, with the expertise of an ostomy nurse or dietician, a policy on the nutritional care of ostomy patients;
- develop a policy regarding the maintenance of fluid balance charts, including in-house training on the policy; and
- review policies relating to early monitoring and whether the facility provides adequate guidance for staff when deciding whether to commence a resident on a fluid balance chart or a nutritional monitoring chart.

4. Pain management

> *"Mrs A's pain was not being assessed appropriately at the facility. Not only does this indicate a lack of care, but it was also contrary to the organisation's policies" (13HDC00405).*

Introduction

Pain is commonly recognised as an issue for residents in RACFs, and it is estimated that between 45% and 80% of residents experience regular pain.[54, 55] However, a large study of nursing home residents in the USA found that even where pain was identified, 25% of residents received no analgesia.[56] The assessment of pain in the elderly can present a challenge. Residents with cognitive impairments, or hearing or speech problems can often find it difficult to report their pain to staff.[57, 58] Furthermore, older people may under-report their own pain for a number of reasons, for example, because they accept pain as part of the aging process or view it as less important that other medical issues.[55, 57]

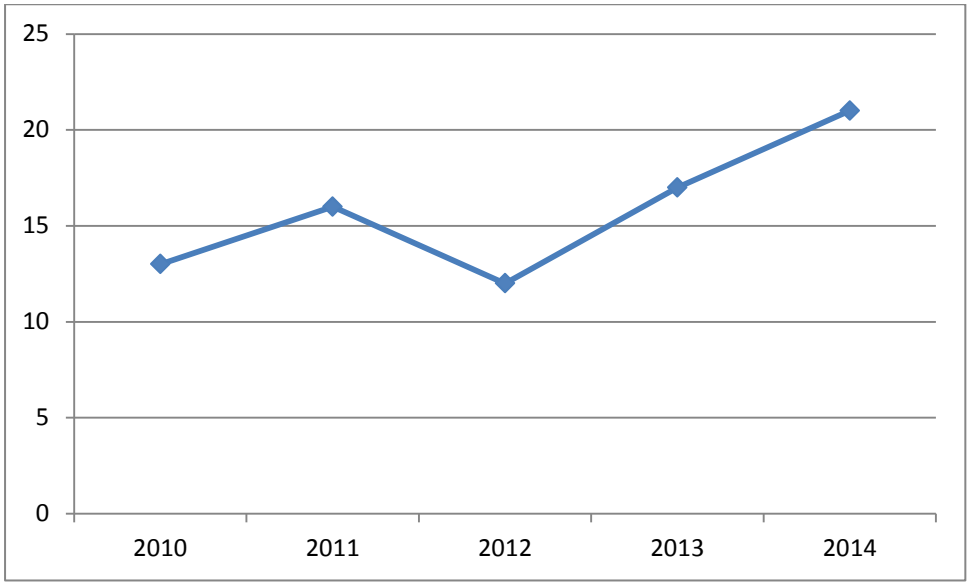
International best practice guidelines suggest using an appropriate pain rating scale to identify a resident's pain. Systematic pain assessment tools that give consideration to the underlying causes of the pain, the pain intensity, and the impact of the pain on the resident should be used. Pain assessment tools should then be used on an ongoing basis during pain management to evaluate pain intensity and assess the effectiveness of the pain management regimen and the resident's response to treatment.[57, 59, 60]

International studies have found a number of barriers to good pain assessment and management practices within RACFs, including: non-standardised approaches to pain assessment; a lack of knowledge among facility staff regarding pain management in elderly people; inconsistent documentation of residents' pain; a lack of time for pain assessment and management; polypharmacy concerns around adverse drug events or interactions; and poor multidisciplinary collaboration on strategies for pain management.[57, 61, 62, 63]

What does the HDC complaint data show?

Complaints alleging that a resident's pain had been inadequately managed by RACF staff were common, with it being at issue in 15% of cases. This is consistent with the international literature, which has found that pain is often undertreated in RACFs. As can be seen in Figure 5, this issue has become more prominent over time, with it increasing from being present in 13% of cases in 2010 to 21% of cases in 2014.

Figure 5. Proportion of cases where inadequate pain management was at issue, by year complaint received



Further analysis of this data showed that inadequate pain management was at issue in 63% of cases regarding the provision of end-of-life care within an RACF. RACFs are increasingly being expected to provide end-of-life care services, with a recent study finding that over half of New Zealanders aged 65 years and older will die in RACFs.[9] This increase in the provision of end-of-life care services by RACFs over time may go some way to explaining the above increase in complaints regarding pain management. This is further supported by international literature, which has found that RACF staff often feel as if they have received inadequate training in pain management for end-of-life care patients, and report issues with communication about pain management across the multidisciplinary end-of-life care team.[64–66]

Further analysis also found that for 37% of cases regarding this issue HDC's expert clinical advisor considered that there had been failure to carry out an adequate pain assessment. This is consistent with research in this area, which has emphasised the difficulty of assessing pain in the elderly and, therefore, the importance of using systematic pain assessment tools for adequate pain management. A common finding in HDC complaints where HDC's expert clinical advisor considered that the pain management was inadequate is that staff lacked training or understanding around the use of pain assessment tools. As mentioned above, this is also often the case in regard to pain management for end-of-life care patients, where RACF staff can lack an understanding around the standards that guide pain management during end-of-life care.

Pain management complaints also often indicated a breakdown of communication between family and staff, where there were conflicting views of the resident's pain. HDC's clinical nursing advisor advised that if a family member's perception is that a resident is in pain, staff should assess the pain

and act accordingly, even in cases where RNs themselves do not think the patient is in pain. It was further advised that the use of formal pain assessments using a pain scale may, in turn, guide discussions with family around how pain may present, as well as allowing family an opportunity to voice their concerns.

Waitemata DHB has guidelines for both RNs and HCAs around assessing, monitoring and managing pain and around end-of-life care.

Case study: Inadequate pain management

Mrs A, a 57-year-old woman with advanced pancreatic cancer, was admitted to an RACF for palliative care.

Several times during Mrs A's admission, she was noted by staff as being in pain on movement, and still in pain after pain relief was administered. On other occasions, Mrs A's daughter, Mrs B, complained that Mrs A was in pain, but at these times the RNs' view was that she was not.

None of the RNs completed a Pain Evaluation/Assessment Chart for Mrs A in line with the facility's Pain Management Policy. Also contrary to this policy, a pain scale was not used and vital signs were not taken. Therefore, no formal pain assessment was ever carried out when Mrs A was documented as being in pain, or when Mrs B thought Mrs A was in pain. None of the RNs sought the advice of a senior staff member or contacted a GP or the hospice.

Mrs B brought a bottle of morphine elixir onto the facility's premises from home. She told RN C that she would administer it to Mrs A herself if RN C would not. RN C did not inform any senior staff members, management, the hospice, or a GP of the incident. Another RN, RN D, later found the morphine elixir in Mrs A's bathroom, but did not take any further action.

HDC's expert clinical advisor advised that when a patient is in pain, or when a family member's perception is that a resident is in pain, staff should assess the pain and act accordingly. She further stated that RNs would be expected to undertake a formal, validated pain assessment, even if the nurse did not think the patient was in pain, and that the use of a pain scale may have in turn "guided discussions with family and provided some indication if additional advice from Hospice or managers should have been sought".

The Deputy Commissioner found a consistent pattern of inadequate and inappropriate documentation of Mrs A's care. For example, there was a failure by staff to update care plans or document specific instructions in Mrs A's progress notes for her care and monitoring once her condition deteriorated. HDC's expert clinical advisor stated that this was important, "particularly monitoring related to pain, agitation and end of life care".

The Deputy Commissioner considered that RN C and RN D failed to comply with professional and legal standards, in Breach of Right 4(2) of the Code, for failing to carry out formal pain assessments; seek further advice or report Mrs A's pain or Mrs B's concerns about her mother's pain; and for failing to take appropriate steps when told that Mrs B had brought morphine, a controlled drug, into the facility, and when the morphine was found in Mrs A's bathroom. The Deputy Commissioner recommended that the Nursing Council of New Zealand consider conducting a review of RN C's and RN D's competence, particularly around controlled drugs, and that RN C and RN D provide a written apology to Mrs A's family for their breaches of the Code.

Multiple staff failed to comply with the facility's Pain Management Policy and Palliative Care Policy. Failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and assist staff to do what is required of them. Accordingly, the Deputy Commissioner found that the facility had failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner also considered that a culture had been allowed to develop at the facility where inadequate documentation was common place, and so found the facility in breach of Right 4(2) of the Code for failing to comply with the Standards in respect of documentation.

The Deputy Commissioner made a number of recommendations to the facility, including that it:

- provide a written apology to Mrs A's family for its breaches of the Code;
- provide HDC with evidence that its Medication Policy has been updated and report on its implementation;
- provide palliative care training to all new registered nurses at induction, and refresher training to all other registered nurses; and
- provide training to all staff about the importance of having comprehensive documentation of a resident's care, including communication with family in the palliative care setting

The recommendations have been met by the facility and by the RNs.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in pain assessment/management include asking facilities to:

- provide palliative care training to all new RNs at induction, and refresher training to all other RNs;
- audit the training of all staff providing palliative care, with particular focus on pain relief;
- conduct an audit to confirm that the facility's pain assessment tool is being used in conjunction with the pain assessment record;
- undertake further training on the use of fentanyl, and monitoring the effects of pain relief in dementia patients using an appropriate pain assessment tool and management plan; and
- adopt objective pain assessment tools, such as the Abbey Scale.

5. Falls

> *"It is unrealistic to expect that residential care can totally prevent falls. Nonetheless, careful management should reduce the incidence of falls among residents with health conditions that put them at greater risk of falling, and it should increase the likelihood that a person will receive prompt medical attention if he or she does fall" (09HDC00987).*

Introduction

Falls are common in older people. Approximately one-third of people aged over 65 years fall each year, and the rate of falls increases with age.[67] The risk of falling is even greater among residents of RACFs. New Zealand studies have found that around 40% of residents will fall within 18 months of living in an RACF.[68]

Falls present a serious health risk to the elderly, and are the leading cause of injuries resulting in hospitalisation and death among older adults in New Zealand.[69] Studies have found that between 40% and 60% of falls in New Zealand RACFs result in injuries, with around 5% resulting in severe injuries.[19, 67] The health risk posed by falls to the elderly has made falls prevention a priority area for older people's health in New Zealand, with reducing falls being one of the goals of the Health of

Older People's Strategy, and "reducing harm from falls" being the focus of a national programme led by the Health Quality and Safety Commission.

Age-related changes in functioning and disease processes mean that elderly people have a number of risk factors that make them prone to falling.[70] Falls are often the result of an interaction between these person-centred, intrinsic risk factors and hazards within the physical environment.[71] Therefore, preventing falls requires an individualised approach encompassing an individual falls risk assessment for each resident, and the development of individualised strategies to minimise falls risk into residents' care plans. The ARRC Services Agreement requires RACFs to have a falls prevention policy in place, which includes programmes to promote safe mobility and the removal of any environmental hazards.

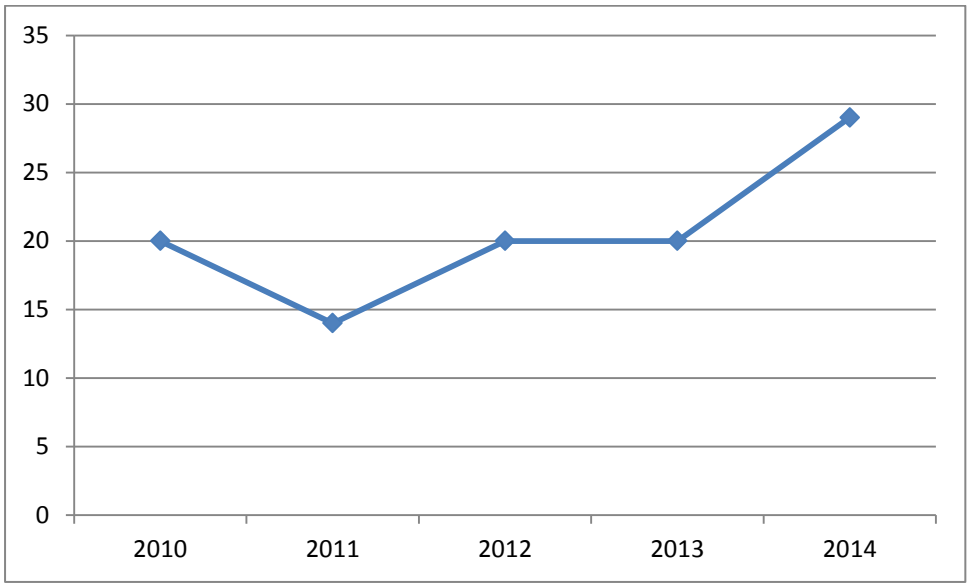
In order to minimise risk of injury and prevent future falls, the assessments and actions taken post-fall are also important. A clinical assessment of the resident immediately following a fall is required in order to identify and manage any injuries.[72] This assessment should also investigate the cause of the fall, as falls can signify underlying conditions or deterioration.[73] In order to prevent future falls, a resident's risk for falls should be re-assessed following a fall, and his or her care plan should be updated, or a new care plan put in place, taking into account any new risk factors.[72] Staff must also document the circumstances of the resident's fall as part of the facility's quality improvement processes in order to develop strategies for preventing future falls and for monitoring the effectiveness of the facility's falls prevention programme.[72, 74]

What does the HDC complaint data show?

Complaints regarding falls were common, with falls being at issue in 20% of cases. This finding is not surprising given how common falls are for older people. The most common falls-related issues complained about were inadequate falls risk management (13%) and inadequate post-fall assessment (13%). Very few complaints involved an inadequate falls risk assessment (2%).

As can be seen in Figure 6 below, the proportion of cases for which a falls-related issue was present remained at around 20% until 2014, when it increased to 28%. This increase may be driven by an increase in complaints regarding an inadequate post-fall assessment, which became one of the most commonly complained about issues in 2014, increasing from being present in around 10% of cases in previous years to 21% of cases in 2014.

Figure 6. Proportion of cases for which a falls-related issue was present, by year complaint received



This data highlights the importance of post-fall assessments. Falls can result in serious health issues for the elderly, such as hip fractures and head injuries. Therefore, it is important that a comprehensive medical assessment is undertaken of residents after they fall, and that relevant healthcare providers are notified of the fall.

Further analysis of complaints involving an inadequate post-fall assessment found that for 13% of these complaints HDC's expert advisor considered that there had been an inadequate pain assessment. This is consistent with the data about pain management outlined above. In 10% of these cases HDC's expert advisor considered that there had been an inadequate neurological assessment. This finding is consistent with the international literature, which has found that there can be a failure to record neurological observations often enough following a fall,[75] with it being suggested that neurological observations should always be carried out if the resident has hit his or her head or if the fall was unwitnessed. This is particularly important given that falls are the most common cause of head injuries among older people.[72]

In 42% of cases involving a fall, the complainant also alleged that communication between providers had been inadequate. These complainants were often concerned that an RN or the resident's GP had not been adequately informed of the resident's fall or of its consequences. Communication between providers is important in the aftermath of a fall. It is important that the resident's GP is notified of the fall, as falls can be a sign of deterioration or an underlying condition. International best practice guidelines suggest that RACF policies around adverse events should guide staff members, according to their level of training, when to call for assistance, and to report all falls even if injuries are not apparent.[76]

In 22% of cases involving a fall, the complainant alleged that there had been a delay in diagnosing the resident's injury post-fall — often this was in relation to a fracture. It should be noted that fractures can be hard to diagnose in older people.[77, 78] However, this highlights the need for a comprehensive medical assessment following a fall, and the need to continue to monitor the resident for any signs of deterioration post-fall.[76, 79]

It is important that facilities have comprehensive policies around the actions that need to be taken post-fall. These policies should outline the responsibilities of RNs following a fall, such as checking the resident for injuries, taking clinical observations, undertaking a pain assessment, notifying family, completing an incident form, re-assessing the resident's falls risk, and giving instructions to HCAs regarding when to seek further RN input, as well as other best practice guidelines is this area. It is just as important that there is a system for monitoring and ensuring that RNs are complying with the facility's policies, and that there is an adequate system for ensuring communication with residents, their families and GPs around post-fall assessment and management.

The Health Quality and Safety Commission and Waitemata DHB have published guidelines around the management of falls in the elderly.

Case study: Falls

Mrs C, a long-term resident at an RACF, had osteoporosis, progressive dementia, and chronic lower back pain. She required full assistance for personal cares, and walked with a mobility frame. During her time in the facility, short-term care plans were not instigated by the Nurse Manager (NM A) in response to a pressure related wound on Mrs C's back, or in response to her suspected UTI.

Mrs C had two falls within a few days. NM A completed an incident form after the first fall, and follow-up was scheduled for when a GP (Dr F) was due to visit the facility. After the second fall, NM A examined Mrs C and instigated a short-term care plan and a pain management plan, but documented few instructions for staff to follow. The day after the second fall, Dr F reviewed Mrs C. However, NM A did not advise Dr F of Mrs C's falls.

NM A did not advise RN B of Mrs C's two falls. NM A then went on leave for 10 days. RN B did not review or familiarise herself with Mrs C's file, incident reports or handover sheets prior to providing nurse manager cover while NM A was on leave. During NM A's leave, RN B noted that Mrs C had new bruising and her left leg was "dragging". RN B did not consider a fracture as a cause of Mrs C's pain. RN B did not seek advice from Dr F or the hospital, and did not advise Mrs C's family of her bruising.

A visiting physiotherapist assessed Mrs C and observed that her left leg was laterally rotated and shortened, and considered that Mrs C had had a recent hip fracture. Mrs C was transferred to hospital by ambulance. A fracture of the neck of femur (hip fracture) was diagnosed.

The Deputy Commissioner identified a number of failures in the use of short-term care plans by staff at the facility, meaning that limited guidance was provided to staff regarding Mrs C's care needs, and management and assessments of treatment efficacy were not consistent. The Deputy Commissioner stated: "In order to provide good care in a rest home environment, residents' care plans must be well documented. A care plan is a fundamental tool that helps enable all staff to provide care that is appropriate and consistent with a resident's changing needs."

The Deputy Commissioner also found that the communication between providers in this case was inadequate. The informal and indirect nature of handover communications between NM A and RN B, along with infrequent use of short-term care plans, meant that important clinical information was not provided adequately to RN B. Additionally, facility policy required all incident/accident forms to be shown to Dr F on his visits. It would, therefore, have been expected that NM A would bring information about Mrs C's falls to Dr F's attention during his visit. HDC's expert clinical advisor was also critical of RN B's failure to seek clinical advice or assistance in response to Mrs C's bruising or dragging of her leg.

The Deputy Commissioner found that NM A and RN B failed to provide services to Mrs C with reasonable care and skill, in breach of Right 4(1) of the Code. NM A was also found in breach of Right 4(5) of the Code for failing to ensure continuity of services, while RN B was found in breach of Right 4(2) of the Code for failing to comply with professional nursing standards. The Deputy Commissioner recommended that NM A review her nursing practice and complete refresher education in care planning, monitoring, and evaluation of treatment efficacy.

It was recommended that RN B review her practice in conjunction with the Nursing Council prior to renewing her practising certificate.

The Deputy Commissioner considered that the system in place for communication between staff at the facility was not effective. There was no formalised policy in place to govern handover and effective communication between the roles of nurse manager and registered nurse. The Deputy Commissioner found that the facility did not take sufficient steps to ensure that appropriate systems, policy and guidelines were in place to provide services to Mrs C with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner made a number of recommendations to the facility, including that it provide HDC with:

- a copy of the in-staff service session on pain management held as a result of the complaint;
- feedback on the effectiveness of staff having access to incident reports when they are on duty;
- an update on the effectiveness of short-term care plans being kept at the front of residents' files so that all staff can access and reference them alongside the staff communication book and progress notes;
- an update on the effect of weekend staffing changes made as a result of the complaint; and
- a clear and comprehensive set of its updated and co-ordinated policies and procedures, including a medicine management policy, an admission policy providing guidelines for staff on understanding and discussing Enduring Power of Attorney status with residents and families, a policy governing effective formal handover from nurse manager to registered nurse, and a policy on the incorporation of short-term care plans, pain management charts and wound care charts in ongoing monitoring of resident care.

The recommendations have been met by NM A, RN B, and the facility.

HDC recommendations

Some examples of the recommendations HDC has made to facilities when it has identified deficiencies in post-fall assessments include asking facilities to:

- revise their falls prevention and management plan to provide direct instructions for the use of a short-term care plan following a fall, particularly when a resident's observations indicate that this may be warranted (for example, where the resident's ability to weight bear alters and/or reported pain levels change);
- undertake an audit of resident falls to ascertain whether staff responded appropriately and in accordance with policy;
- review their falls management policy to ensure that an incident form is completed for all fall events;
- provide training to staff about their policy on head injury management;
- implement staff training to ensure that nursing staff are aware of expected clinical assessments and procedures following an incident, particularly when a resident has sustained an injury;
- provide HDC with a copy of the checklist tool implemented by the facility to ensure that standardised post-fall assessments are carried out by nurses;
- provide training to staff around when care needs to be escalated to a resident's GP following a fall;
- ensure that all caregivers and other staff adhere to the resident falls policy; and
- ensure that a registered nurse is notified of a resident's fall.

6. Wound care

"I consider that both pressure area care and the maintenance of skin integrity are critical components in the provision of [residential] care" (12HDC01229).

Introduction

Increasing age negatively impacts both on the ability of individuals to heal from wounds, and on their susceptibility for developing wounds.[80] Wounds have been found to be a source of significant pain,[81] and are associated with a poorer quality of life and increased morbidity and mortality for older people,[82, 83] as well as constituting a burden on healthcare resources.[82, 83]

The high prevalence of wounds in RACFs means that wound prevention and management is an important part of clinical care in RACFs. A New Zealand study found that around 7% of residents in RACFs had a pressure ulcer, and around 15% of residents had a high risk of developing pressure ulcers.[19] Australian studies have found that skin tears are the most common wound type for residents, with around 22 skin tears occurring each month in RACFs.[86]

The ARRC Services Agreement requires RACFs to have a wound care management policy, and to document all skin tears and pressure ulcers as an adverse event. New Zealand and international best practice guidelines suggest that all residents should receive an assessment of their risk for wound development on admission to a facility. Those residents identified at risk for wound development should then have individualised preventative interventions documented in their care plans, incorporating a multidisciplinary team approach to wound management. A resident's wound care risk will need to be re-assessed and a new preventative plan formed in response to changes in the resident's condition or upon the development of any wounds.[87, 88]

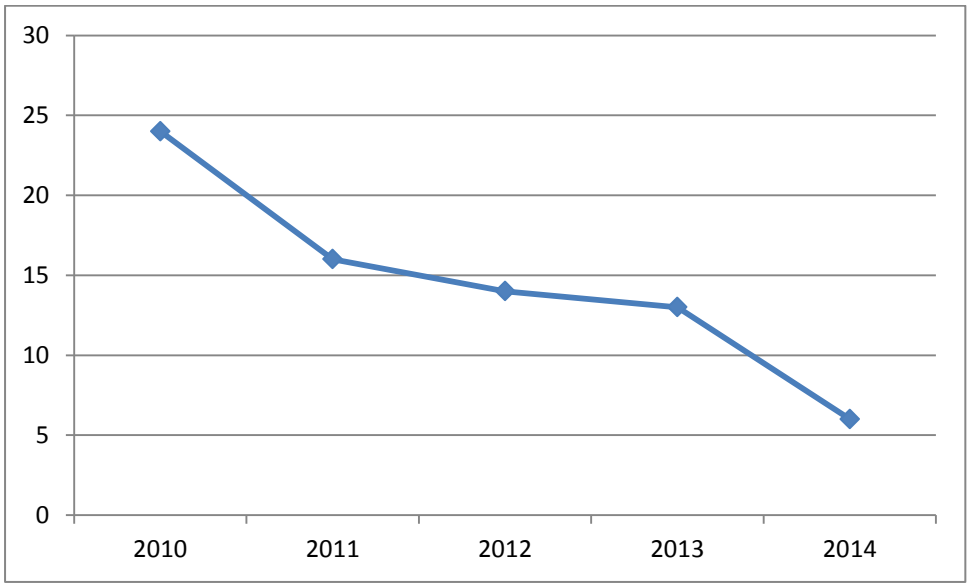
Due to age-related changes to residents' skin, and their risk factors for wound development, the prevention of all wounds in RACFs is not possible. When a wound does develop, international best practice suggests that a comprehensive assessment of the wound is required to develop the most appropriate treatment plan. This assessment needs to be frequent and on-going.[80, 87] As with falls, it is also important that RACFs systematically record the development of all wounds and analyse and evaluate these events for quality improvement.

What does the HDC complaint data show?

Wound care was at issue in 15% of cases in the HDC complaint data. This is consistent with older people's higher risk for wound development and impaired healing. The most common wound care related issue was inadequate wound management, with this issue being present in 13% of cases. Relatively few cases involved an inadequate wound assessment (4%) or inadequate wound monitoring (4%).

As can be seen below in Figure 7, the proportion of cases for which a wound care related issue was complained about decreased markedly over time from 24% of cases in 2010 to 6% in 2014. This finding is encouraging.

Figure 7. Percentage of cases for which a wound care related issue was complained about, by year complaint received



In 80% of cases involving wound care, the complainant was also concerned about a failure to communicate effectively with the resident's family. This often reflected substandard communication with family around adverse events, with family members reporting that they had not been told by staff that the resident had developed a wound, or had not been kept informed of the consequences of the wound (such as any infections). Family members were also often concerned that their knowledge of the resident's risk for wound development, or their wound management requirements, had not been listened to by staff. International best practice guidelines emphasise the importance of involving family in wound risk assessment and management. A family's knowledge of the resident can be useful to staff in risk assessment, and their involvement can often increase the success of risk management strategies.[80, 88, 89]

In 62% of cases involving wound care, it was also alleged by the complainant that communication between providers had been inadequate. As mentioned above, the multidisciplinary team is important in both wound prevention and the treatment of existing wounds, with allied health professionals and GPs having important roles to play. Although wound care management is overseen by RNs within facilities, HCAs are often best placed to look for and note the development of any wounds or changes to existing wounds. Therefore, good communication between providers within the facility is important to successful wound care management.

The management both of a resident's risk for wound development and of any existing wounds is dependent on the robust use of care plans and comprehensive documentation of the care provided. Inadequate communication between providers and inadequate care planning are common features of complaints about wound care. Detailed care plans around wound management, and thorough documentation specifying the treatment provided and assessments and observations made, provide a clear line of communication about the resident's wound status. This allows RNs to ensure that care is being provided in line with the resident's needs.

The failure to identify wound deterioration is a common issue identified by HDC in wound care complaints that have undergone formal investigation. The on-going monitoring and assessment of wounds is essential to providing adequate treatment. Current practice in wound care is to record a wound assessment at each change of dressing. Many facilities use a wound chart that provides

guidance on what needs to be assessed. This allows each dressing change and assessment to be recorded accurately, and ensures that the practice is consistent across all healthcare staff. It also assists staff to monitor the effectiveness of the treatment provided, and makes wound deterioration or failure to heal easier to detect.

Facilities require a robust and thorough wound care management policy based on best practice guidelines. Facilities need to ensure that all staff are aware of the policy, and that it is followed consistently. For wound care management to be consistent and systematic, robust policies around documentation and care planning also need to be adhered to by staff.

Waitemata DHB has guidelines for both RNs and HCAs around skin management, and the Australian Wound Management Association, in collaboration with the New Zealand Wound Care Society, has produced guidelines for the prevention and management of pressure injuries.

Case study: Wound care

Mr A, a 70-year-old man, was admitted to an RACF for 18 days of respite care. Mr A had multiple co-morbidities, including type II diabetes. Mr A's left leg had been amputated below the knee, and his right foot had two chronic infective ulceration wounds on his big toe and heel. Mr A also had a skin tear on his right leg.

During his time at the facility, Mr A's right foot wounds deteriorated, particularly his right big toe, which became necrotic. In addition, it was suspected that Mr A had a urinary tract infection. An RN called Mr A's GP (Dr C), who prescribed antibiotics. Despite evidence of necrosis, the nursing staff at the facility did not request that Dr C review Mr A in person, nor did they inform Dr C of the deterioration of Mr A's wounds.

Two days following his discharge from the facility, Mr A was admitted to hospital with gangrene of his right big toe. Subsequently his right leg was amputated above the knee.

The Deputy Commissioner considered that there were a number of deficiencies in Mr A's admission assessment and care plan. There was no record of whether skin or pressure risk assessments were conducted, and no care plan was developed for Mr A on how to avoid pressure area risks and maintain skin integrity. These were critical components of care for Mr A, whose chronic wounds were at increased risk of poor or delayed healing, and who was at a high risk of pressure areas owing to his diabetes and poor blood circulation. Additionally, no wound care plans were completed for the wounds on Mr A's right toe, right heel, or left stump as part of his admission assessment.

The Deputy Commissioner also found that Mr A's wounds were not managed adequately by the nursing staff at the facility. Mr A's wounds were not identified and assessed in a timely manner and, once they were identified, the wounds were not reviewed regularly and were not managed in accordance with his wound care plans. At no point was Dr C called to assess Mr A's wounds. There was no oversight of Mr A's wounds by one registered nurse. Almost every wound care review was performed by a different registered or enrolled nurse. This affected the ability of nursing staff to identify changes to Mr A's wound status appropriately. As a result, there was no continuity with the dressing changes and the reviews undertaken by the nursing staff.

Furthermore, the Deputy Commissioner was critical of deficiencies around the standard of documentation and communication with Mr A's family. Given the large number of staff members attending to Mr A, it was important that progress notes were clear, to enable those on the next shift to provide appropriate care. HDC's expert clinical advisor noted that the "daily notes of [Mr A's] general condition and care of [his] wounds appear[ed] insufficient and [made it] difficult to follow continuity of treatment". Additionally, there was no consultation with Mr A's family around his admission assessment or care plan, and Mr A's family were not kept well informed about the changes in his health status.

The Deputy Commissioner considered that the problems that arose in Mr A's care were not the result of

isolated incidents, and many of the shortcomings were common to a number of staff, indicating systemic problems within the facility. Therefore, the Deputy Commissioner found that the facility failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code. It was also found that the facility's documentation and communication with Mr A's family did not meet professional standards, in breach of Right 4(2) of the Code.

The Deputy Commissioner made a number of recommendations to the facility, including that it:

- provide a written apology to Mr A;
- conduct an audit of its wound care documentation;
- conduct a review of the effectiveness of the introduction of a wound care nurse;
- confirm its plans to ensure timely contact and follow-up with GPs and conduct a review of the effectiveness of this;
- provide to HDC a list of in-service training courses offered by the facility for registered and enrolled nurses for the next calendar year, with the courses offered to include such topics as documentation, wound care, care planning admission assessments, and communication;
- use the investigation report as a basis for staff training at the facility, focusing particularly on the breaches of the Code identified; and
- conduct an audit of patient records to assess compliance with documentation policies and professional standards.

The recommendations have been met by the facility.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in wound care management include asking facilities to:

- develop a policy on the incorporation of appropriate short-term care plans, pain management charts, and wound care charts in ongoing monitoring of resident care;
- provide details of a policy regarding when caregivers should contact a registered nurse when evaluating a wound, ensuring that the policy describes to caregivers the features of wound deterioration — such as increased oedema and exudate — that would warrant contacting a registered nurse;
- amend their wound management policy regarding the management of pressure areas to ensure that all wounds of two months or longer are reviewed by a wound specialist or GP;
- undertake a review of the training provided to staff in relation to diabetes management, prevention and management of pressure areas, and pressure ulcer care;
- provide training to staff in the documentation of pressure wound care, and ensure that wound assessment and treatment tool forms are recorded accurately and updated as necessary;
- provide staff training on the management, tracking and benchmarking of pressure wound injuries;
- remind staff, particularly healthcare assistants, to document when residents are turned or repositioned for pressure area care; and
- create a protocol for when referral to a wound specialist is appropriate.

7. Deteriorating condition

"Mr A's deterioration over the 16 days that followed was not managed promptly or decisively by rest home staff, or in accordance with his care plan. It is concerning that it was not until [16 days later] that action was finally taken to respond to Mr A's deteriorating condition … this was clearly inappropriate and inadequate care" (11HDC00423).

Introduction

Residents in New Zealand RACFs can often require acute health care due to exacerbations of chronic illness or their predisposition to the development of new illnesses.[8] This means that clinical care staff within facilities must be alert to signs of clinical deterioration among residents. The issues reported in this section will be more applicable to hospital-level and dementia-care facilities than to facilities providing rest-home care. It should be noted that in the context of end-of-life care, it may not be appropriate to perform further investigation or monitoring of a deteriorating patient.

The management of clinical deterioration in RACFs can be complicated by the fact that deterioration can become harder to diagnose and treat as people age. Infections tend to present atypically or asymptomatically in the elderly, fever can be harder to measure, diagnostic tests can be harder to perform, there is a high rate of antibiotic-resistant pathogens and complications among residents, and co-morbidities and cognitive impairment can make identifying symptoms and obtaining an accurate medical history difficult.[90, 91]

However, early detection and prompt and effective management of clinical deterioration can minimise adverse outcomes and decrease the number of interventions required to stabilise the patient. International guidelines[92] emphasise the importance of assessing and monitoring physiological observations, such as temperature and respiration rate, with adequate frequency to recognise and respond to clinical deterioration. It is therefore important that these monitoring requirements are clearly communicated to all members of the healthcare team, and that all observations are recorded and documented consistently. International guidelines[92] recommend that trigger thresholds are developed, where a physiological parameter, or assessment of a group of such parameters, trigger escalation of care.

Within RACFs, the ARRC Services Agreement and New Zealand best practice guidelines[93] emphasise the importance of starting a short-term care plan or revising the resident's current care plan in response to any deterioration in the resident's condition. These care plans should be used to communicate any information around the frequency of observations required, thresholds for escalation of care, and treatment plans to all staff. It is important that these care plans are discussed with, and reviewed by, the resident's GP and any other relevant health professionals. This is supported by international research findings that GP intervention is effective in reducing the need for emergency department transfer.[94]

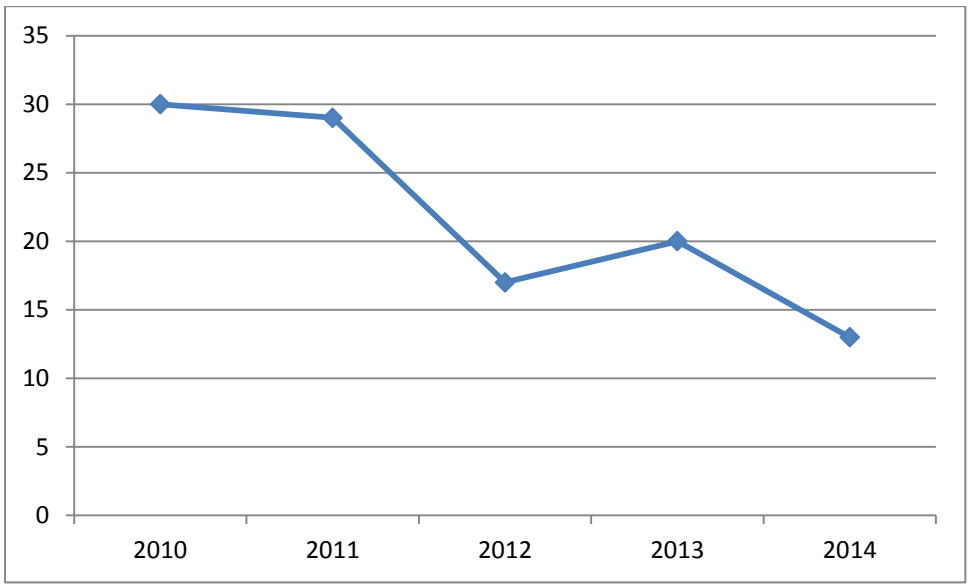
What does the HDC complaint data show?

Complaints regarding the recognition/management of a person's deteriorating condition were common, with this issue being present in 22% of cases. This is consistent with the high numbers of residents in RACFs with chronic diseases and co-morbidities. No one issue within the deteriorating condition category was responsible for a large proportion of these complaints.

As can be seen below in Figure 9, the proportion of RACFs complained about in relation to the recognition/management of a consumer's deteriorating condition has decreased over time from

being present in 27% of cases in 2010 to 15% in 2014. This finding is encouraging given the increasing dependence of residents in RACFs over time.

Figure 9. Percentage of facilities for which the recognition/management of a consumer's deteriorating condition was complained about, by year complaint received



Further analysis of the cases regarding the recognition/management of a resident's deteriorating condition found that in 17% of these cases HDC's expert advisor considered that there had been an inadequate assessment or monitoring of the resident's vital signs. Guidelines in this area emphasise the importance of recording and monitoring residents' observations in order to recognise and respond appropriately to clinical deterioration.[92, 93] Failing to assess and monitor these observations adequately can result in a delay in recognising clinical deterioration and, therefore, a delay in the resident's care being escalated for medical review or specialist care. RACFs should have policies and procedures that assist staff to recognise when a resident is deteriorating clinically, and when to escalate care and obtain further clinical advice.

An inadequate care plan was identified in 17% of these cases. Continuity of care is important to the recognition of clinical deterioration and, therefore, comprehensive care planning and documentation are essential. Best practice guidelines emphasise the value of using the resident's care plan to communicate to the healthcare team the clinical observation monitoring requirements, the physiological signs and symptoms that require escalation of care to a senior member of staff or a GP, and the details of any interventions such as the administration of antibiotics. This is especially important in RACFs, where much of the care is being provided by HCAs under the supervision of RNs, and requires organisations to have a culture and systems that support staff to follow policies and value the importance of documentation.

In 35% of cases involving a deteriorating condition, the complainant also alleged that there had been a delay in referring the resident to specialist care when his or her condition required it. This emphasises the importance of facility staff keeping residents' GPs informed of clinical deterioration, as GP intervention has been found to reduce hospitalisation and ensure that residents obtain appropriate medical assessment and treatment early on in the process. However, 55% of cases involving a deteriorating condition also involved inadequate communication between providers.

Waitemata DHB has guidelines for both RNs and HCAs around assessing, monitoring and managing various changes in consumers' conditions.

Case study: Deteriorating condition

Mrs A, an 81-year-old woman, was receiving rest-home level care in an RACF. Mrs A had multiple co-morbidities, including chronic obstructive pulmonary disease (COPD) and ischaemic heart disease, and was taking multiple medications.

RN C was an inexperienced graduate nurse employed to provide registered nurse duties at the facility where Mrs A lived, as well as at another facility owned by the same company. RN C was employed under the supervision of a Clinical Services Manager for about three months. When the Clinical Services Manager resigned, no subsequent arrangements were made to find a replacement. RN C registered his concerns with management that, for a period of time, he was left to cover RN duties at two facilities without any clinical supervision.

Mrs A developed a cough and was losing her voice. Three days later, Mrs A was not feeling well, and did not want to eat. No short-term care plan was put in place to inform HCAs of any monitoring or interventions required.

Two days later, RN C recorded some basic observations, including that Mrs A had diarrhoea. RN C contacted a GP by fax requesting a prescription for the anti-diarrhoea drug loperamide. RN C did not provide the GP with any other information regarding Mrs A's symptoms, and did not consider that further intervention was required. RN C put an isolation notice on Mrs A's door as an infection control precaution, but did not send any specimens for testing.

RN C was not working at the facility for the following two days, but he was on call. In RN C's absence, Mrs A vomited and it was noted that she was barely eating. Despite various HCAs documenting Mrs A's deterioration and an HCA noticing Mrs A's weight loss, no staff contacted RN C.

When RN C returned to the facility, an HCA told him that she felt that Mrs A needed to see a doctor. RN C assessed that Mrs A was in danger of dehydration and encouraged fluids. He did not organise a medical review. That night Mrs A had an episode of diarrhoea. She was given loperamide, and night care staff were instructed by RN C to encourage fluids and monitor Mrs A. No vital signs or observations were recorded, and no fluid or food chart was initiated. RN C considered that an emergency admission/assessment did not appear to be necessary, and instead planned to call a GP first thing the next day.

The next morning, RN C made an appointment for the GP to visit Mrs A later that morning. However, before the GP visit could take place, Mrs A was noted to be very unwell, and RN C called an ambulance. Hospital staff considered that Mrs A had a diarrhoeal illness with acute renal impairment, heart failure, and a respiratory tract infection. Sadly, Mrs A passed away in hospital.

The Deputy Commissioner considered that RN C did not assess or monitor Mrs A's condition adequately in line with nursing competencies, sector standards, or the facility's procedure for registered nurse assessment. The expert clinical advisor stated that "assessment, monitoring and evaluation of Mrs A's vital signs and condition were inadequate and could be considered a severe departure from accepted practice". Additionally, care planning for Mrs A was inadequate, and RN C failed to obtain a medical assessment or a diagnosis despite multiple entries in the records that Mrs A was unwell. The Deputy Commissioner therefore found that RN C failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

The Deputy Commissioner also considered that RN C's documentation was inadequate. As a result of poor documentation, important information about Mrs A's condition was not available to the entire team caring for Mrs A. This, in tandem with RN C's lack of short-term care plans, which have an inherent communicative function, meant that RN C did not provide important information about Mrs A's changing clinical

circumstances to other staff, and this contributed to the lack of continuity in Mrs A's care, in breach of Right 4(5) of the Code. The Deputy Commissioner recommended that RN C provide a formal written apology to Mrs A's family for his breaches of the Code, and that he provide HDC and the Nursing Council of New Zealand with full details and documented evidence of all the professional nursing supervision, mentoring activities and educational development he had undertaken to meet RN competencies.

The Deputy Commissioner was critical of the facility's decision to assign an inexperienced graduate nurse, without clinical supervision, responsibility for the direction and delegation of care for facility residents. She considered that this was "unreasonable and unsafe" owing to RN C's relative inexperience, and placed both the residents and RN C at risk. The expert clinical advisor stated that "the lack of appropriate supervision, RN staffing hours and skill mix leading up to Mrs A's change in health status and hospitalisation undoubtedly contributed to inadequate clinical reasoning". The facility did not take sufficient steps to ensure that appropriate systems were in place to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner was also concerned that the inaction of multiple staff to adhere to policies and procedures pointed to an environment that did not support and assist staff sufficiently to do what was required of them. Despite instruction in the long-term care plan, Mrs A's vital signs and weight were not recorded regularly by staff, and, when faced with Mrs A's deteriorating condition, HCA staff did not contact the on-call nurse in line with policy, or seek assistance. These failings were contributed to by the lack of an explicit process for accessing medical services out of hours. By failing to ensure that staff were complying with policies and procedures, the facility failed to comply with professional standards, in breach of Right 4(2) of the Code.

The Deputy Commissioner made a number of recommendations to the facility, including that it:

- provide a formal written apology to Mrs A's family for its breaches of the Code;
- develop a system of multidisciplinary morbidity/mortality review of residents who become seriously unwell and/or are transferred to hospital or die in its care;
- implement the Registered Nurse Care Guide and the Caregiver Guide for residential aged care. These guides contain relevant evidence-based practice management for residential care;
- conduct a full review of policy and procedure; and
- develop and provide HDC with a clear and comprehensive set of updated and co-ordinated policies and procedures, including policies that govern staff accessing medical care after hours and in emergencies, the effective use of short-term care plans, and the steps taken to ensure staff compliance with policies and procedures.

The recommendations have been met by RN C and the facility.

HDC recommendations

Some examples of recommendations HDC has made to facilities when it has identified deficiencies in recognition/monitoring/management of clinical deterioration include asking facilities to:

- develop a system of multidisciplinary morbidity/mortality review of residents who become seriously unwell and/or are transferred to hospital or die in their care;
- review policies and procedures around staff accessing medical care after hours and in emergencies;
- review policies and procedures to ensure that consumers identified as being unwell receive half-hourly checks, are more closely monitored, and have appropriate documents initiated;
- remind RNs of the need to document baseline observations when residents are unwell;

- complete a documentation audit to ensure that unwell residents are being monitored appropriately;
- provide in-house training on the clinical records policy to ensure that staff document assessments and observations regardless of whether vital sign readings are normal or abnormal;
- organise in-house training for staff on the recognition and management of patients suffering a possible cerebrovascular event; and
- review the Temperature and Respiration Recording policy and include a guideline to determine which patients should have these assessments and the frequency required.

POLICIES AND PROCEDURES

"Without staff compliance policies become meaningless."

A common finding on assessment of complaints about RACFs is that a failure by staff to follow the facility's policy and procedures was a contributing factor to care deficiencies. The failure by multiple staff to adhere to policies and procedures points towards an environment and culture that does not support and assist staff sufficiently to do what is required of them, something for which the facility must bear overall responsibility.

Facilities must ensure that they have policies and procedures that are consistent with relevant standards, and that they have systems in place to ensure that staff are complying with these policies. These systems should allow for the effective oversight and monitoring of staff. Compliance also requires facilities to ensure that they have in place sufficient support for staff to allow them to follow policies and procedures, for example, ensuring RN or GP availability for escalation of concerns regarding a resident's care. Facilities should also have training and education programmes that provide training for new staff, and refresher training for current staff, on aspects of their policies and procedures to ensure that staff have the sufficient skills to follow policies and procedures.

HDC recommendations to RACFs where a failure to follow policies/procedures has been identified will often include asking facilities to audit compliance with the policies/procedures at issue and ensure that training is provided to staff around the care deficiencies identified.

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APPENDIX: COMPLAINT ISSUES

Communication

- **Disrespectful manner/attitude**, e.g., insensitive/inappropriate comments, insulting or impolite manner, dismissive of resident/resident's family's concerns, etc.
- **Failure to communicate effectively with consumer**, e.g., failure to listen to consumer's needs/preferences, failure to provide consumer with information/explanation about changes in their care, etc.
- **Failure to communicate effectively with family**, e.g., failure to tell family of change in consumer's condition/adverse event, failure to listen to family's preferences for consumer's care, failure to provide family with information/explanation about changes in consumer's care, etc.
- **Inadequate communication between providers**, e.g., failure to pass on information about consumer's care to GP, failure to notify GP of change in consumer's condition/adverse event, inadequate handover between staff within facility, failure to tell registered nurse of change in consumer's condition/adverse event, etc.
- **Inadequate response to complaint** where complainant had first made complaint directly to facility management but was dissatisfied with its response, e.g., did not agree with facility's explanation/version of events, response to complaint was not timely, did not feel as if facility had made the necessary changes to stop such an event occurring again, did not feel listened to by management, etc.
- **Retaliation/discrimination as a result of complaint** where complainant felt he or she had suffered poor care or adverse effects as a result of making a complaint.

Consent

- **Consent not obtained/adequate** where complainant felt as if consumer's consent for type of care/procedure had not been adequately obtained by facility.
- **Issue with Enduring Power of Attorney/advance directive** where complainant felt as if consent had not been obtained adequately from the consumer's Enduring Power of Attorney by facility, or facility had not followed an advance directive adequately.

Documentation

- **Inadequate care plan**, e.g., failure to initiate short-term care plan in response to changes in consumer's condition, failure to document all the necessary requirements for the consumer's care in his or her individual care plan, etc.
- **Failure to follow care plan**, failure to carry out requirements for consumer's care as set out in his or her individual care plan.
- **Inadequate/inaccurate documentation**, e.g., failure to document changes in consumer's condition, observations/assessments carried out, treatment provided, conversations with other providers regarding consumer's care, etc.
- **Inadequate/inaccurate incident report**, failure to complete an incident report adequately in response to an adverse event, e.g., a fall.
- **Intentionally misleading/altered documentation** where documentation has been intentionally changed retrospectively to reflect an inaccurate version of events.

Facility

- **Cleanliness issue**, e.g., facility smells like urine, toilets/showers not cleaned regularly, consumer's room dirty, etc.
- **Failure to follow facility's policies/procedures** when caring for consumer.
- **General safety issue** for consumer in facility, e.g., consumer assaulted by other residents, consumer had repeated falls, consumer left secure facility, consumer injured by unsafe/faulty equipment in facility, etc.
- **Inadequate infection control** throughout facility.
- **Inadequate policies/procedures**.
- **Inadequate staffing levels** to meet consumer's needs.
- **Inadequate supervision/skills mix**, e.g., registered nurses not adequately supervising healthcare assistants' or enrolled nurses' care, not enough registered nurses in facility to meet consumer's needs, staff do not have required skills to carry out care, etc.
- **Issue with management of facility**.
- **Issue in sharing facility with other consumers**, e.g., concerns about the noise levels of other residents, concerns about threatening/harassing behaviour of other residents, theft by other residents, etc.
- **Issue with quality of aids/equipment**, e.g., concerns about faulty equipment, consumer's equipment needs/preferences not followed, etc.
- **Issue with quality of food**, e.g., consumer's food preferences not followed, issue with temperature of food provided, food unappetising to consumer, etc.

Falls

- **Inadequate assessment** of consumer's risk for falls.
- **Inadequate management** of consumer's risk for falls, e.g., sensor mats not used, inadequate fall hazard management within facility, consumer should not have been walking unassisted, etc.
- **Inadequate post-fall assessment**, e.g., no neurological examinations carried out, inadequate pain assessment, vital signs not taken, etc.

Restraint

- **Inadequate assessment** of consumer's need for restraint.
- **Inadequate monitoring** of restraint use for consumer.
- **Inadequate management** of consumer's need for restraint, e.g., inappropriate forms of restraint used, restraint used for an inappropriate length of time, etc.

Fluid/nutrition

- **Inadequate assessment** of consumer's risk for dehydration.
- **Inadequate monitoring** of consumer's fluid intake, e.g., failure to start or adequately complete a fluid balance chart for consumer, etc.
- **Inadequate management** of consumer's risk for dehydration, e.g., inadequate amount of fluid offered to consumer, etc.
- **Inadequate assessment** of consumer's nutritional needs/risk for malnutrition.
- **Inadequate monitoring** of consumer's nutritional intake, e.g., failure to monitor consumer's weight regularly, failure to start or adequately complete a food intake chart for consumer, etc.

- **Inadequate management** of consumer's nutritional need/risk for malnutrition, e.g., nutritional supplements not provided to consumer, diabetic diet not followed adequately, soft food diet not provided appropriately, etc.

Incontinence

- **Inadequate assessment** of consumer's incontinence.
- **Inadequate management** of consumer's incontinence, e.g., inadequate use of incontinence pads, consumer not toileted regularly, inadequate catheter management, etc.

Wound care

- **Inadequate assessment** of consumer's risk for wound development.
- **Inadequate monitoring** of consumer's skin integrity/current wound healing.
- **Inadequate management** of consumer's wound care/risk for wound development, e.g., dressings not changed regularly, inappropriate dressings used, pressure relieving mattresses not used, etc.

Deteriorating condition

- **Inadequate assessment/recognition** of consumer's changing condition, e.g., urine sample not taken, observations not taken, failure to recognise symptoms of respiratory distress, failure to recognise symptoms of a cardiac event, etc.
- **Inadequate monitoring** of consumer's deteriorating condition, e.g., vital signs/observations not taken regularly, oxygen levels not monitored, etc.
- **Inadequate management/treatment** of consumer's deteriorating condition, e.g., fluid not increased in response to UTI, antibiotics not given regularly for infection, failure to follow diabetes management plan, failure to request a medical review when indicated.

Other clinical care

- **Delayed/inadequate referral** of consumer to specialist/secondary care.
- **Inadequate discharge/transfer**, e.g., complainant disagrees with reasoning for consumer's discharge from facility, appropriate discharge policies not followed, consumer's discharge delayed, inadequate communication between facilities when consumer transferred, etc.
- **Inadequate needs/admission assessment**, e.g., failure to undertake/adequately complete consumer's admission assessment, needs assessment not sought in response to consumer's changing condition, needs assessment failed to adequately identify level of care required, etc.
- **Missed/delayed diagnosis**, e.g., delayed diagnosis of fracture following a fall, delayed diagnosis of UTI, delayed diagnosis of sepsis following wound infection, etc.

Other non-clinical care

- **Delay in attending**, e.g., delay in responding to consumer's call bell/requests for assistance.
- **Hygiene needs not met**, e.g., consumer not showered often enough, consumer left lying in urine/faeces, consumer's clothes not washed often enough, consumer's dentures not cleaned, etc.
- **Inadequate supervision of residents by staff**, e.g., when consumer fell, consumer was assaulted by another resident, consumer left a secure facility, etc.

- **Mishandling of consumer**, e.g., consumer dropped from hoist, incorrect transfer techniques used, consumer handled roughly by staff, etc.
- **Personal privacy not respected**, e.g., consumer's door left open, family's privacy not respected by staff, etc.

Medication

- **Administration error**, e.g., incorrect dose administered, incorrect drug administered, etc.
- **Missed/delayed administration**, e.g., medication was not administered at the correct time, or a dose of the medication was not administered.
- **Over-medication**, e.g., concern that consumer had been prescribed too many medications, concern that dose of medication was too high, concern that medication was having an adverse sedative effect, etc.
- **Inadequate pain management**.

Professional conduct

- **Allegation of assault** of consumer by a staff member.
- **Allegation of disrespectful behaviour** displayed by staff towards consumer or consumer's family.
- **Financial exploitation** of consumer by a staff member.
- **Refusal to assist/attend** — allegation that staff deliberately refused to respond to consumer's call bell/requests for assistance.
- **Threatening/harassing behaviour** — allegation that consumer or consumer's family felt harassed or threatened by staff.
- **Inappropriate collection/use/disclosure of information** — allegation that staff breached a consumer's privacy.