Radius Residential Care Limited

Registered Nurse, RN C

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC00525)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a woman at Radius Elloughton Gardens, and highlights the importance of having a culture that encourages staff to speak up, ensuring that staff follow policy, and of clear and accurate documentation.

2. Sometime during the night and the next morning, the woman (who had an intellectual disability and limited communication skills) suffered a right shoulder dislocation, as well as a fracture of her left tibia and fibula.[1] It was determined that these injuries were most likely a result of the woman falling, and, as she could not get in and out of bed by herself, it was most likely that a staff member was with her when the injuries occurred.

3. However, all staff denied having any knowledge of how the woman sustained her injuries, and multiple inconsistencies in their recollections were provided to Radius. There was also no documentation between the hours of 7.48pm and 9.34am the following day and, as a result, Radius was unable to establish how the injuries occurred.

4. In addition, whilst the injuries were discovered at approximately 9.30am, an ambulance was not called until 2.27pm. Subsequently, the woman passed away.

Findings

5. The Deputy Commissioner found that Radius did not provide appropriate care and services to the woman, as the woman suffered serious injuries in its care, and it is likely that at least one of its staff members was involved. In addition, staff failed to adhere to Radius's policies, there was a delay in getting the woman to hospital, there was a pattern of poor documentation by its staff members, and the training provided to its nursing staff was inadequate. As such, the Deputy Commissioner found Radius Residential Care in breach of Right 4(1) of the Code.

6. The Deputy Commissioner considered that the failures by a nurse were largely caused by the lack of adequate systems in place at Radius Elloughton Gardens to provide appropriate support and training to her, and, as such, did not find the nurse in breach of the Code. However, adverse comment was made about the care she provided to the woman following the discovery of the woman's injuries, and her poor standard of documentation.

Recommendations

7. The Deputy Commissioner recommended that Radius undertake a review of all current individual staff training records; conduct random audits of staff compliance with its policies; prepare educational sessions for training its staff regarding open disclosure, adverse event management, and documentation; undertake meetings with staff and management to discuss the apparent practice of its staff spending time in other wings during their shifts, completing notes hours after completing tasks, and recording notes of observations that they did not see; provide HDC with an update on its consideration of the

[1] The two bones in the lower leg that connect the knee to the ankle.

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external investigator's recommendation that CCTV be installed; use an anonymised version of this report as a basis for staff training; consider whether any of the learnings from this investigation can be translated into improvements throughout its other aged-care services; and provide the woman's family with a written apology.

8. The Deputy Commissioner also referred Radius Residential Care Limited to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

9. The Deputy Commissioner recommended that the nurse undertake further training on falls and escalation of care, and provide the woman's family with a written apology.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her aunt, Ms A, by Radius Elloughton Gardens. The following issues were identified for investigation:

- *Whether Radius Residential Care Limited (trading as Radius Elloughton Gardens) provided Ms A with an appropriate standard of care in 2018.*
- *Whether RN C provided Ms A with an appropriate standard of care in 2018.*

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

12. The parties directly involved in the investigation were:

Ms B	Consumer's niece/complainant
Radius Elloughton Gardens	Rest home/provider
RN C	Registered nurse/provider

13. Also mentioned in this report:

Ms D	Health care assistant
RN E	Registered nurse
Ms F	Health care assistant
Ms G	Health care assistant
Dr H	General practitioner

14. Further information was received from:

District Health Board
HealthCERT

15. Independent expert nursing advice was obtained from RN Julia Russell (Appendix A).

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Information gathered during investigation

Background

16. Ms A, aged in her seventies at the time of events, had been a resident at Radius Elloughton Gardens (Radius) since 2017, when her previous aged-care facility had closed down. Ms A had a medical history that included an intellectual disability, a previous fracture to her left fibula,[2] bipolar disorder,[3] osteoarthritis,[4] and osteoporosis.[5] Radius's Assessment Comments form noted that Ms A was reported to be a positive and sociable person with no issues regarding challenging behaviour.

17. Ms A resided in a hospital-level wing consisting of approximately 23 residents requiring hospital-level care.[6] Ms A had spent most of her life in residential facilities owing to her intellectual disability, and required assistance with most aspects of daily living. She had limited communication skills (although she could understand staff when she was given instructions clearly and slowly), and required a four-point walking frame as well as assistance by one person when mobilising. Her care plan recorded that she also required assistance to mobilise from her bed or chair, but she was noted to be a low falls risk.

18. This report relates to an event at Radius that caused significant injuries to Ms A, and the care provided to her following the event.

Events on Day 1[7] and Day 2

19. At 1.43pm on Day 1, Ms A was noted to be "eating and drinking as tolerated", and no concerns were documented by the care staff during the day. The last note in her progress notes for the day was documented at 7.48pm by a health care assistant (HCA), who stated: "Washed, changed clothes and pad, settled to bed after cares, cleaned dentures and put it in the container, no new concerns."

20. Radius stated that usually Ms A would sleep well and not wake during the night, and would be disturbed overnight only for routine checks to see if she needed her incontinence pad changed. Radius noted that Ms A required assistance to get in and out of bed, and was inclined to call out for assistance rather than use her call bell.

21. Between 8pm on Day 1 and 9.30am on Day 2, approximately 16 care staff (a mixture of health care assistants and registered nurses) were on duty, and Radius stated that during this time there were no visitors or outside contractors in the facility.

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[2] Calf bone.

[3] A mental disorder that can cause unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks.

[4] The most common form of arthritis, which occurs when the protective cartilage that cushions the ends of a person's bones wears down over time.

[5] A condition where the density and quality of a person's bones are reduced, making them weak, brittle, and more likely to fracture.

[6] Hospital-level care is used to describe the high level of attention, care, and support required.

[7] Relevant dates are referred to as Days 1–8 to protect privacy.

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22. An HCA stated that at some point during her shift (which was from 2.45pm to 11.15pm), she checked on Ms A while she was asleep; however, this was not documented, and the time of the HCA's observation is unknown. The HCA stated that she had no concerns when she checked on Ms A.

23. HCA Ms D started her shift at Radius at 11pm on Day 1, and provided cares for Ms A at 1.30am and 4.30am on Day 2. Ms D stated that she changed Ms A's pad by herself at 4.30am. Ms D did not record her cares in the progress notes, but documented in Ms A's bowel chart that Ms A had had a "Type 7" bowel movement at 6.01am on Day 2. However, Ms D denied that this occurred, and could not explain why she entered the information into Ms A's bowel chart.

24. All other staff on the late night shift denied that there were any incidents involving Ms A during their shifts.

25. The night nurse, RN E, said that around 6am she walked through the wing. She stated that she did not go into any of the rooms, but had a quick look from the door side, and all the patients appeared to be fine. RN E said that it was not a busy night, and the HCAs did not report any fall or incident to her.

26. There are no further entries in Ms A's progress notes or charts until 9.34am on Day 2. The handover report between the night shift and the oncoming morning shift did not mention any concern about Ms A. However, on the morning of Day 2, Ms A was found to have suffered severe injuries.

Care provided to Ms A on Day 2

27. On Day 2, RN C was the rostered nurse in the wing from 6.45am until 3.15pm. She told HDC that when she started her shift she received handover from RN E, who did not report any issues with Ms A. However, RN C told HDC that around 7.15am, when she was preparing medication for the morning medication round, she overheard a conversation between two of the night HCAs about a fall that had occurred overnight. She said that she was focused on preparing the medications, and did not pay attention to what the HCAs were saying. RN C stated: "I only made the connection much later, that what [the HCAs] were saying in the nurses' station may have referred to [Ms A] having a fall." RN C said that the care staff did not inform her directly that they had concerns about Ms A.

28. The two night HCAs in question (Ms D and Ms F) deny that this conversation occurred.

29. RN C then started the morning round, which included giving Ms A her medications. RN C said that she had a brief conversation with Ms A during the medication round, and Ms A was "fine" and had "no complaints of pain". This was not documented in the progress notes. RN C told HDC:

> "While I was with [Ms A] for about five to ten minutes, she did not mention any fall or report any pain to me. I didn't notice anything unusual about her condition, or state, other than that the bed was very neat and tidy."

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30. At 9.34am, HCA Ms G documented in Ms A's personal cares chart that all of her cares had been performed, including that she had been washed, dressed, her dentures cleaned, and her bed made, and that after the cares had been completed, Ms A was seated on her chair in her room. The documentation also noted that Ms A was "eating and drinking less, not well" and that the registered nurse had been informed. This exact note is also documented by Ms G in Ms A's progress notes at 2.50pm. The correct time at which the care was provided, or whether Ms G documented in the progress notes retrospectively, is unclear.

31. Ms G later told Radius that whilst she documented that she had performed Ms A's personal cares (in both the progress notes and personal cares chart), she did not actually perform the cares for Ms A on this day, and she documented the cares on behalf of two other HCAs. Ms G did not provide an explanation for why she did this.

Nursing review

32. RN C stated that around 9.30am (the exact time is unknown), the caregivers informed her that there was something "unusual" about Ms A, and asked her to review Ms A. RN C told HDC:

> "[O]ne of the care staff reported to me that [Ms A] had pain in her right hand and was refusing to change her clothes during the morning cares. She said that [Ms A] had said she had had a fall early in the morning."

33. RN C said that she went to Ms A's room immediately and found her on her bed half-dressed, with one of the care staff trying to put a top on her, which was half on.

34. RN C stated that when she got to Ms A's room, Ms A was "really screaming and yelling because of [the] pain", and would not let RN C touch her. RN C said that usually Ms A was very compliant and cooperative, so this was unusual behaviour for her, and she could see a bright red area on Ms A's shoulder.

35. RN C told HDC that she then tried to undertake a head-to-toe assessment as thoroughly as she could. She stated that Ms A indicated that she had pain and redness on her right upper arm, and that the pain score was 9 out of 10. RN C said that she asked Ms A several times whether she had fallen, but Ms A did not reply. RN C stated that Ms A also complained of pain (5 out of 10) in both legs, and could bend both knees around 35 degrees. RN C did not document these assessments in the progress notes.

36. The nursing review performed by RN C was not documented until 6.00pm that day (see below at paragraph 48). The documentation recorded only Ms A's vital signs, and did not include the pain assessment as stated by RN C above.

37. RN C told HDC that she was concerned about Ms A's level of discomfort when being moved, so she instructed the three care staff who were watching her to leave Ms A on the bed while she contacted the general practitioner (GP) to request a review of Ms A. RN C stated that she told the care staff not to move Ms A. RN C then left to get pain relief (30mg of codeine), which was administered to Ms A at 10.30am with "no effect". RN C told HDC:

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> "I was not satisfied with pain analgesics and [Ms A's] reluctance to cooperate with the cares and her unusual screaming on assessment pushed me to add her name in afterhours GP's list."

38. At some point after administering the codeine (the time is unknown as it was not documented), RN C contacted the receptionist at the Medical Centre advising that she suspected that a patient had had an unwitnessed fall, and a review by the GP was needed.

39. RN C also sent a fax to the Medical Centre, which stated: "[Ms A] … Severe pain on right hand (near elbow region). Couldn't move her lower limbs too. She suggests to see the GP."

40. Subsequently, RN C was informed that the GP would review the patients at approximately 12pm. In response to the provisional opinion, RN C told HDC that at the time of contacting the Medical Centre, she was not aware that the GP would not review Ms A until 12pm because he had a morning clinic.

41. RN C said that after she had telephoned the GP's office at around 11am, she returned to check on Ms A, and found that the care staff had moved Ms A from the bed to the chair, against her advice. RN C told HDC:

> "At the time I was very disappointed to see that the care staff had ignored my specific instruction, but I did not have the opportunity to speak to them about it, as I was trying to attend to all other tasks that day and to managing [another resident]."

GP review

42. The afterhours GP, Dr H, attended Radius Elloughton Gardens sometime between 12.45pm and 1pm. Dr H told HDC:

> "I was asked to visit the patient at 12pm on [Day 2] … I saw the patient at about 1pm. (exact time not recorded) … [T]he afterhours nurse told me that patient had fallen and injured their arm. I am not sure which rest home nurse contacted the afterhours clinic (or how) … I examined the right arm and advised that the patient go immediately to [the Emergency Department] for further assessment and x rays (she was in a lot of pain and so needed further examination in [Accident and Emergency] with acute pain relief). I advised the nurses that the patient needed to go quickly to [Accident and Emergency] for x rays and further assessment."

43. Dr H documented his review in Ms A's Radius progress notes at 12.47pm, as follows: [Ms A] … had fall and now right arm and elbow pain [on examination] very tender arm and elbow … send to [Accident and Emergency] for x rays."

44. RN C told HDC that Ms A seemed very concerned about Dr H touching her, and "cried out" when he tried to examine her arm. RN C stated that once Dr H had reviewed Ms A, she accompanied Dr H to review another patient who had a blocked catheter and a fever. RN C said that after Dr H left, she checked on Ms A frequently, and each time she was still sitting

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quietly in her room or was asleep, and she did not report any pain when asked. RN C also said that Ms A had eaten from her morning tea and lunch trays, which reassured her.

Transfer to hospital

45. Ms B told HDC that RN C called her about Ms A's condition around 2.04pm. Ms B stated: "[T]he nurse denied anything had happened on their shift. We didn't know injuries at that stage."

46. RN C rang 111 at 2.27pm requesting an ambulance for Ms A. RN C told HDC that this was her first opportunity to call the ambulance since the doctor had left, as she had had to finish the lunchtime medication round, ring Ms A's next of kin, seek guidance from the Clinical Nurse Manager, and help a district nurse to tend to another resident who required a catheter change, which took "longer than expected" and which the district nurse was finding difficult. In addition, RN C told HDC that there are a number of tasks that are required to be undertaken to transfer a patient, and she had not received any supervision or support with this, and had not experienced having to transfer a patient previously.

47. The ambulance arrived at Radius at approximately 2.40pm. The attending ambulance personnel documented that Ms A was difficult to communicate with owing to her special needs, and appeared agitated when the attending personnel tried to gather more information regarding her injuries. Ms A refused to go to hospital, and Ms B was called to assist staff with moving Ms A onto the stretcher. The ambulance departed Radius with Ms A at 3.38pm and took her to the Emergency Department at the public hospital.

Documentation of events on Day 1–Day 2

48. RN C retrospectively documented the events of the day, including the result of her nursing review, in Ms A's progress notes at 6.03pm, as follows:

> "[Ms A] had [complained of being] sore in her right hand and her both legs as well, noted by care givers during her cares, she had severe sore while changing the position and she told that she had a fall in the early morning. She suggested to see doctor too. While assessed she was screaming and refusing to touch her both extremities because of sore, not come out of the room and was in her room for lunch and the whole morning as well. Vitals checked, [temperature] 36.2, [oxygen saturation] 96, [respiratory rate] 16, [blood pressure] 130/80 mm of Hg, [pulse] 74. Gave [as needed] codeine at 10.30am with no effect. Informed after hours GP about this and he came assessed her, suggested x-ray and informed the family about this. Called ambulance and when ambulance came, she was not cooperative to the ambulance staff to go to hospital and informed [Ms B] (relative) about this and she came and explained about everything what had happened and took her to the hospital with the ambulance staff at 3.20pm."

49. The progress notes contain no further documentation by Radius's nursing and healthcare staff from 7.48pm on Day 1 until 6.03pm on Day 2 (except for the notes by the caregiver at 2.50pm).

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50. RN C told HDC that as she was trying to do her best for both residents (Ms A and the resident with a blocked catheter), she had no time to complete the progress notes. RN C said that she had not stopped all day and had had no food. She stated:

> "The notes do not reflect everything that happened, and I accept that my documentation does not reflect all of the relevant information and should have been a better record."

51. RN C did not complete an incident form, and said that this should have been completed by the night shift staff when Ms A fell. However, she stated that during her shift she checked in with the night nurse about Ms A's fall, and the night nurse responded that there were no concerns about Ms A on the night shift. RN C told HDC that because she had finished her shift so late and was so exhausted by the events, it did not occur to her at the time that she was required to complete the incident report, given that the night nurse did not know about a fall. RN C also stated:

> "I had advised the CNM[8] on the day of what had happened. I was not told that I needed to do an incident report nor was I told to do a full record in the progress notes given it was a serious event that was likely to become and did become, the subject of an internal and external review. I was not encouraged to make a full record of events that day or the following morning when I could have expanded on the details of what had occurred."

52. RN C accepts that she has learnt much from the experience, including the need for more thorough documentation.

53. Radius was unable to locate observation charts, including neurological assessments covering Day 1 and Day 2, or an incident form for Ms A's suspected fall.

54. Radius said that it "understands that observations, including neurological assessments were done on [Day 1] and [Day 2], but that … these observations and assessments were not recorded on [Ms A's] clinical file". Radius stated that it "accepts that these observations and assessment should have been recorded".

55. Radius told HDC that it also accepts that an incident form should have been completed at the time of the fall, as per its "Falls Assessment and Intervention" policy (discussed further below). Radius said that it "accepts that there is a lack of information/documentation in respect of this incident".

Hospital review and subsequent events

56. Ms A was admitted to hospital at around 4.00pm[9] on Day 2. She was found to have suffered a right shoulder dislocation, as well as a periprosthetic fracture[10] of her left tibia

[8] Clinical Nurse Manager.

[9] The DHB discharge summary stated that she was admitted at 4.00pm; however, the ambulance service told HDC that the ambulance arrived at the hospital at 4.40pm.

[10] A broken bone that occurs around the implants of a joint replacement.

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and fibula. Ms B told HDC that she was told by medical staff at the hospital that Ms A "was now in palliative care, and would never walk again".

57. Ms B said that at 7.38pm on Day 2, she received a telephone call from one of the nurses, who asked about Ms A's condition. Ms B told HDC: "I told her about the injuries … I asked what had happened to [Ms A] — Nurse couldn't tell me."

58. Ms B said that she and her sister met with Radius Management on Day 4, and advised them of Ms A's injuries. Ms B told HDC: "[T]hey were shocked as no staff had let them know on [Days 2 or 3]."

59. Hospital medical staff determined that Ms A's injuries were not for surgical management, and a plan was made for her to be discharged on Day 8, and to remain on bedrest and be kept comfortable and pain free. Ms A was transferred back to Radius, and subsequently passed away a few days later.

Subsequent investigation

Radius internal investigation

60. On Day 4, the Facility Manager at Radius was advised (for the first time) by Ms B that Ms A had suffered injuries on Day 2. The Facility Manager contacted the Regional Manager of Radius, and it was determined that it was necessary to commence an immediate investigation into the matter.

61. The internal investigation comprised interviews with all staff on duty at the time of the incident, multiple fact-finding meetings to cross-reference the information obtained, and a full staff meeting to encourage anyone with information that could assist the investigation to come forward. It was noted that Ms A would not have been able to return herself to bed after sustaining her injuries, and would have required considerable assistance from another person or persons.

62. The investigation took place over the week beginning Day 4. Radius said that a total of 16 staff members were interviewed and a compulsory meeting held for all staff, at which staff were advised that the investigation had yet to produce any leads, and were encouraged to come forward with any information that could assist the investigation.

63. However, all staff denied having any knowledge of how Ms A sustained her injuries, and the following inconsistencies in recollections were noted in the investigation report:

- RN C recalled overhearing Ms F and Ms D discussing a fall that had occurred overnight; however, both HCAs deny saying this, or that this occurred.
- There were differences in accounts as to who served Ms A with breakfast early on the morning of Day 2.
- RN E, the night nurse on Day 1 to Day 2, stated that two to three days after the incident, Ms D told her that she had changed Ms A's sheets at 4.30am on Day 2; however, Ms D denies saying this, or that this occurred.

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- There is documentation under Ms D's name in Ms A's bowel chart that she had a "Type 7" bowel movement at 6.01am on Day 2. However, Ms D denied that this occurred, and could not explain why she entered this information into Ms A's bowel chart.
- An HCA stated that Ms A's bed was a mess in the morning, and had food and urine on it; however, RN C noted that Ms A's bed had been freshly made and was not messy as it usually was.
- Ms D and Ms F clocked out from their shift 40 minutes late, and, when asked why, they stated that it had been a "crazy night"; however, other night staff recalled the shift being quiet.

External investigation

64. On 12 December 2018, Radius engaged an external investigator to review and make sense of the documentation and audio recordings of the staff interviews. A copy of the investigation report was provided to HDC and, in summary, the external investigation found the following:

a) It appeared that the injuries suffered by Ms A were the result of a fall, or the attempt to lift/pull her off the floor to return her to bed.

b) On the grounds of probability, the injuries sustained occurred between 11pm on Day 1, and 7am on Day 2.

c) It was more likely than not that the incident occurred when Ms D took Ms A to the toilet at 6.01am, as even though Ms D denies this, she cannot explain why she entered in Ecase (Radius's documentation software) that Ms A had had a bowel motion, and multiple staff members recall Ms D stating that she changed Ms A's sheets at this time.

d) There was a practice of staff spending time in other wings during their shifts, and a practice of staff completing notes hours after completing tasks, or recording notes of observations that they did not see. The external investigator stated that this is an on-going risk to Radius that needs to be considered.

e) The use of CCTV in the corridors would have greatly assisted the investigation, and it was recommended that CCTV be installed to increase security.

Conclusion of Radius's investigation

65. On 11 April 2019, Radius sent a letter to Ms A's family and provided them with the result of the investigation and a copy of the investigation report. The letter stated:

> "We are very sorry we are unable to give you the answers you are seeking. We appreciate this has been an incredibly stressful and difficult time and apologise again for the distress this has caused to you and your family."

66. Radius concluded that it conducted an intensive and robust investigation into the incident as soon as it was made aware of the same, and accepts that a number of inconsistencies

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emerged from its investigation. Radius stated that these inconsistencies were investigated both internally and externally, but "unfortunately were not able to be reconciled". Radius told HDC:

> "Radius takes the care of all its residents very seriously. Radius deeply regrets that [Ms A] suffered injuries while in [Radius Elloughton Gardens], and that it was not able to determine how these injuries were sustained."

Training

67. RN C told HDC that she obtained her nursing qualifications overseas in 2011, and previously had worked as a theatre and surgical nurse, but had had no previous rest-home experience. She stated that in her home country, there is no rest home care system, and the healthcare system is entirely different. She began working at Radius in 2018, and told HDC that she was provided with very little proper orientation before she started work, with no orientation or guidance on Radius's policies or procedures. RN C told HDC that when she asked for more training, she was told that this "would have to happen later as [Radius was] too short-staffed".

68. RN C stated that at the time of these events, she had had no experience with a resident falling, or of transferring a resident to hospital. Also, prior to the events she had not had to complete an incident form, or to access after-hours GP care. RN C also stated that prior to these events she had not received training on eCase documentation, and was not aware that an incident form needed to be completed for a fall even if the fall had occurred on another shift and had not been reported at handover.

69. Radius told HDC that as part of RN C's three-month orientation programme she was required to read Radius's policies and procedures. However, because RN C was off work with an injury for several weeks, her orientation programme was put on hold.

70. Radius also noted that RN C was required by the Nursing Council to complete a Competency Assessment Programme prior to receiving her Annual Practising Certificate. Radius stated that completing notes and reporting issues with clients are covered as part of standard competencies in the programme.

71. HDC was provided with RN C's orientation programme. It includes an orientation checklist in which RN C has signed next to each competency (including Radius's policies and procedures). However, the date on which each specific competency was completed is not noted. The programme also included a registered nurse appraisal form, in which the "self-assessment" section was completed by RN C and signed; however, the manager's assessment section is blank.

72. RN C told HDC that she did not complete the orientation booklet until after these events.

73. Training documents were also provided to HDC, showing that prior to these events RN C received training in syringe driver competency, handwashing, restraints, wheelchair

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competency, oxygen use, and medication administration. However, she was not provided with training on Ecase until Day 6.

Changes made since events

Radius

74. On Day 4, Ms B notified the funding DHB for Radius Elloughton Gardens about the events regarding Ms A. At this time, the DHB had several concerns about Elloughton Gardens, which related to other resident complaints, non-compliance with the ARC agreement,[11] and the concerning presenting condition of two of its residents at the DHB's Emergency Department.

75. On 18 December 2018, Statutory Management was put in place at Elloughton Gardens. In a letter to the Regional Manager of Radius dated 18 December 2018, the DHB stated:

> "After much consideration between HealthCERT, and [the Chief Executive Officer for the DHB] we are of the opinion that the health and safety of residents is at high risk of being compromised in the current environment present at Elloughton Gardens … We have no other option but to place Elloughton Gardens under Temporary Management."

76. A temporary manager was allocated to work alongside the regional and local Radius managers to address the areas that required improvement, and admissions to the rest home were suspended, effective immediately, for an eight-week period whilst a plan of action was implemented to mitigate the risk to residents.

77. Radius told HDC that this process involved a complete review of staffing, management, and leadership, as well as significant additional training of its staff members. Radius stated that in addition it has developed a three-month work plan for the Clinical Nurse Manager, which involved employing the services of an experience external clinical nurse manager to provide additional training and coaching to the Clinical Nurse Manager around risk management, assessment, coaching, and management skills.

78. Radius stated that since this incident it has implemented a benchmarking system for its registered nurses to enable them to measure their performance in terms of outcomes such as falls, rate of injuries with falls, and compliments and complaints. In addition, Radius also now ensures that all registered nurses work as a team to complete care plans in a timely manner.

RN C

79. RN C told HDC that she has learnt many things from this experience. She stated that as part of the significant changes made by Radius, she was provided with education and training, and has learnt about the importance of documentation, of seeking appropriate

[11] The national contract for age-related residential care between district health boards and aged residential care providers.

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senior advice, and of task prioritisation and critical thinking when multiple situations are occurring at once.

80. RN C said that since 2019, she has been working as a theatre nurse for a DHB.

Further information

Ms B

81. Ms B told HDC:

> "A lot of the carers and patients were extremely upset about what had happened to [Ms A] as she was so well liked by everyone. My Aunt was a special needs person and didn't know how to tell a lie …"

RN C

82. RN C stated:

> "I am very sorry that [Ms A] had a fall and that she passed away and I am very sorry that [Ms B] feels that the care I provided to [Ms A] was not adequate … I want to reassure [Ms A's] family and the HDC, that during the morning when [Ms A] was sitting in her room that she did not seem in pain. If she had been reporting to me that she was in pain, I would have rung the [Clinical Nurse Manager] and if I couldn't speak to her, taken steps to send [Ms A] to hospital straight away, rather than call the GP to review."

Radius

83. Radius told HDC:

> "Radius accepts that there is a lack of information/documentation in respect of the incident … Radius had made all reasonable efforts to determine the circumstances of the incident. As also set out above, Radius has spent significant time and resources reviewing its practices, and training staff on reporting requirements and responsibilities when any adverse event occurs."

HealthCERT

84. HealthCERT noted that the latest Ministry of Health surveillance audit of Radius Elloughton Gardens (conducted in October 2019) found that all standards and criteria audited were fully attained. HealthCERT noted that the statutory manager was still in place (as of August 2020), and told HDC that it was satisfied with the DHB's management of the facility.

Policies

Falls assessment

85. At the time of these events, Radius had a policy for "Falls Assessment and Intervention" (dated March 2018). The policy stipulated:

> "• Prior to moving the client, a thorough assessment of the client must be carried out. Ask the client if they have any pain, and if so location. Check for soft tissue

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trauma i.e laceration and/or haematoma, indications of a fracture i.e. deformity of abnormal rotation of limbs, head and/or neck injury.

- If there is an obvious deformity of a limb, or suspicion of a fracture, do not move the client, phone immediately for medical assistance or an ambulance.

…

- Following a fall, clients require close monitoring and observation. Ensure vital signs are monitored and documented. If the client sustained trauma to the head, or the fall is unwitnessed, the client must be monitored.
- The neurological records should be taken hourly for the first four hours and if stable four hourly for 48 hours … All neurological observations should be done in conjunction with the resident's vital signs, pulse, B/P, respiratory rate and temperature. These are to be recorded on the neurological observation chart and the TPR chart.

…

- Following a fall an incident/accident form must be completed, and documentation of the fall, injuries, treatment and on-going monitoring of the client documented in the multidisciplinary progress notes.
- The client's family/whānau must be notified …"

Event reporting

86. At the time of these events, Radius had a policy titled "Accident/Incident Event Reporting" (dated March 2018). The policy stated:

"• Any employee that identifies an incident should report it by completing an incident form … the incident form should be completed as soon as possible and before the end of the working duty …

- All NOK[12]/EPOA[13]/whānau/family must be informed of the incident on that shift or at the nearest appropriate time but must be within 24 hours."

Clinical records

87. At the time of these events, Radius had a policy titled "Clinical Records" (dated June 2016), which stated:

[12] Next of kin.

[13] Enduring powers of attorney.

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"Key principles of health record documentation:

The following principals are necessary for effective record keeping. Each entry in a consumer/patient health record shall:

a) Document each:
- Assessment
- Event
- Visit
- Treatment
- Procedure
- Consultation

b) Be recorded as soon as practicable after an event has occurred …

…

e) Be factual, consistent, accurate, legible and complete"

Responses to provisional opinion

88. Ms B was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. She stated that her main concern was that someone is held accountable for the lack of action and documentation in this case.

89. Radius was provided with an opportunity to comment on the full provisional opinion. It stated that it was concerned with the conclusion that there were significant systems issues at Radius Elloughton Gardens at the time of the events of this complaint, and disagreed that it failed to ensure that its staff were adequately trained to provide care to its residents.

90. Radius referred to the mandatory external surveillance and certification audits of April 2018[14] and October 2019[15] (which show that all standards and criteria audited were "fully attained") as evidence of the above.

91. In addition, Radius stated:

"To the extent that staff were uncooperative with Radius' attempts to discover what happened and/or provided conflicting information and/or provided dishonest information, Radius says it is not responsible."

92. RN C was provided with an opportunity to comment on the relevant sections of the provisional opinion, and her lawyer stated on her behalf:

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[14] https://www.health.govt.nz/sites/default/files/prms/audit_summaries/AuditSummary_PRMS_CommunicatePublish_000008424001.pdf

[15] https://www.health.govt.nz/sites/default/files/prms/audit_summaries/AuditSummary_PRMS_CommunicatePublish_000013804001.pdf

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"It is accepted by [RN C] that she could have provided better documentation and it is unfortunate that as a new, orientating and junior nurse that she was not encouraged to go back and review and complete her documentation, including providing an incident report the next day when it was clear to Elloughton Gardens that [Ms A] had suffered a significant fall on the night shift.

In relation to the delay however, there are circumstances … which it is respectfully submitted, could be given greater emphasis. These include that … [RN C] was managing another very unwell patient who appeared to be more acute. Further, the fact that this was a weekend made a significant difference to the timing of both seeing a doctor and then being able to attend to both patients and to then calling the ambulance. As [RN C] said in her substantive response, if at any time [Ms A] had been expressing pain or discomfort she would have contacted the ambulance straight away and not waited for the GP to attend."

93. Other comments provided by RN C have been added to the report where relevant.

Relevant standards

94. The New Zealand Nurses Organisation Standards of Professional Nursing Practice (NZNO Standards of Practice) states:

"Nurses are responsible and accountable for their practice.

Nurses:

…

1.4: provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate;"

95. The Nursing Council of New Zealand (Nursing Council) Code of Conduct for Nurses (Nursing Code of Conduct) states:

"**Principle 4**

Maintain health consumer trust by providing safe and competent care

Standards

…

4.8 Keep clear and accurate records …"

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Opinion: Radius Residential Care Limited — breach

Introduction

96. The New Zealand Health and Disability Services Standards (NZHDSS) require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.[16] Radius had the ultimate responsibility to ensure that Ms A received care that was of an appropriate standard and that complied with the NZHDSS and the Code of Health and Disability Services Consumers' Rights (the Code). Radius also had an obligation to provide adequate training and support to allow its care staff to work to the best of their ability, and to ensure compliance with its policies and procedures.

97. Ms A had been a resident of Radius Elloughton Gardens since 2017, owing to her intellectual disability and complex health needs. She resided in a hospital-level wing, and required assistance with most aspects of daily living.

98. I consider that at the time of these events, significant systems issues were present at Radius Elloughton Gardens and had a direct impact on the level of care provided to Ms A. Ms A was let down by various aspects of the care provided to her by several staff at Radius Elloughton Gardens. My expert advisor, RN Julia Russell, stated:

> "[T]he concerns regarding the management of Elloughton Gardens [and] the issues [and] deficits that led to the situation were [rooted] in the systems running at Elloughton Gardens."

99. I agree with this advice, and also note that following these events, Radius Elloughton Gardens was placed under temporary management by the DHB. Ms A's intellectual disability meant that she was a particularly vulnerable consumer who relied heavily on Radius to provide her with an appropriate standard of care. She was less well equipped to convey her needs fully and, as such, she was dependent on staff to monitor and identify signs of ill health or injury. Accordingly, it was extremely important that all aspects of her care be well planned, with timely interventions delivered consistently by all nursing and support staff.

100. This investigation has highlighted that although the various policies and procedures in place at Radius Elloughton Gardens to guide patient care were in themselves sound, the fact that multiple staff did not follow them consistently meant that service delivery was sub-optimal. In my opinion, this indicates failures at a systemic level at Elloughton Gardens. As such, I have found Radius Elloughton Gardens in breach of the Code for the reasons outlined below.

[16] NZS 8134.1:2008, Standard 2.2.

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Unknown incident on Day 1–Day 2

101. On Day 1, Ms A was noted to be "eating and drinking as tolerated", with no concerns documented by the care staff during the day. Nothing documented in Ms A's progress notes, charts, or the handover report between the night shift and the oncoming morning shift raised any concerns about Ms A and her well-being. However, at approximately 9.30am on Day 2, Ms A was found to have suffered severe injuries, which eventually were diagnosed as a right shoulder dislocation and a periprosthetic fracture of her left tibia and fibula.

102. Radius told HDC that between 8pm on Day 1 and 9.30am on Day 2, approximately 16 care staff (a mixture of health care assistants and registered nurses) were on duty, and that no visitors or outside contractors were in the facility during this time. Radius noted that Ms A would not have been able to return herself to bed after sustaining her injuries, without considerable assistance from another person or persons.

103. However, staff members' recollections were inconsistent with one another and with the documentation of the evening, and each staff member denied having knowledge of anything having occurred. Despite both an internal and an external investigation, the circumstances surrounding Ms A's injuries were not uncovered. The external investigation mainly found that Ms A's injuries were likely the result of a fall or the attempt to lift or pull her from the floor to return her to her bed and that, on the balance of probabilities, the injury occurred between 11pm on Day 1 and 7am on Day 2.

104. Given the evidence available to me, I am also unable to make a factual finding as to what exactly occurred that caused Ms A's injuries, and specifically when she suffered these unknown injuries.

105. In any event, I accept Radius's investigation report that during the night shift between 11pm on Day 1 and 7am on Day 2, something occurred that caused Ms A to break her leg and dislocate her shoulder, and it was likely to have been a fall. In my opinion, given the evidence available, and on the balance of probabilities, it is evident that at least one Radius staff member had knowledge of the events that occurred, and that this person failed to speak up when asked. Staff were uncooperative with Radius's attempts to discover what had happened, and the conflicting recollections by various staff members indicate that some staff were dishonest. In my view, this is indicative of a culture at Elloughton Gardens that did not support its staff to advocate for the residents and speak up when they observed poor care or when mistakes occurred.

106. My expert advisor, RN Julia Russell, advised:

> "[T]his remains a serious situation as the resident involved was seriously injured and died ... From all the material provided and the [letter from Radius's lawyer] it appears there were significant system issues present at Elloughton Gardens at the time of this incident and that the actions taken as part of the statutory management has addressed the issues. Despite this, at the time of the incident Radius Elloughton

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Gardens did not meet the expected standards of an aged care provider and this was a serious departure from the standards."

107. I agree. Ms A was a vulnerable consumer owing to her intellectual disability, and she relied on Radius to keep her safe. Radius failed in this regard. It is immensely concerning that Ms A suffered serious injuries whilst in its care, with the knowledge of at least one staff member, yet the circumstances around these injuries remain unknown. The failure of Radius staff to speak up when these injuries occurred led to a delay in Ms A receiving pain relief and necessary medical assistance.

Subsequent management of Ms A's condition on Day 2

108. Ms A's injuries were discovered at approximately 9.30am on Day 2 by care staff, who requested that RN C review her. RN C said that when she attended, Ms A was "screaming and yelling because of [the] pain", and would not let RN C touch her. RN C asked the care staff to leave Ms A on the bed because of her pain, but they moved Ms A from her bed to her chair against RN C's advice. Codeine was given to Ms A at approximately 10.30am, with "no effect". There is no evidence that any Radius staff undertook hourly observations of Ms A as per Radius's "Falls Assessment and Intervention" policy.

109. RN C telephoned and faxed a request for the after-hours GP to review Ms A, and was told that he would attend at approximately 12pm. Dr H attended Radius Elloughton Gardens sometime between 12.45pm and 1pm. Dr H told HDC that he advised the nurses that Ms A needed to go "immediately" to Accident and Emergency for X-rays and further assessment; however, RN C did not request an ambulance for Ms A until 2.27pm. RN C said that she was unable to request an ambulance immediately because she had to finish the lunchtime medication round, ring Ms A's next of kin, seek guidance from the Clinical Nurse Manager, and help a district nurse to tend to another resident who required a catheter change.

110. Radius's Falls Assessment and Intervention policy states:

"Following a fall, clients require close monitoring and observation. Ensure vital signs are monitored and documented. If the client sustained trauma to the head, or the fall is unwitnessed, the client must be monitored.

The neurological records should be taken hourly for the first four hours and if stable four hourly for 48 hours … All neurological observations should be done in conjunction with the resident's vital signs, pulse, B/P, respiratory rate and temperature. These are to be recorded on the neurological observation chart and the TPR chart."

111. I will be discussing further the care provided by RN C in the section below at paragraph 134. In any event, I note that once Ms A's injuries were discovered, many of Radius's care staff failed to act in accordance with its policies and procedures. Ms A was moved against the advice of the registered nurse, her neurological observations were not monitored, and

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there was a delay in both seeking GP review and calling an ambulance. As a result, I am critical of the care provided to Ms A following the discovery of her pain on Day 2.

Documentation

112. I am also concerned about the standard of documentation by Radius staff in this case.

113. On the overnight shift of Day 1 and Day 2, an event — most likely a fall — occurred, resulting in Ms A suffering severe injuries. However, nothing about the event is documented in the overnight notes, and no incident form was completed, as required by Radius's "Falls Assessment and Intervention" policy. An HCA stated that at some point during the overnight shift she checked on Ms A whilst she was asleep, but this was not documented and the time is unknown. Ms D completed cares for Ms A at 1.30am and 4.30am, but the cares were not documented. The only documentation for this overnight shift was a note made by Ms D that Ms A had had a bowel movement at 6.01am, but Ms D denies that this occurred.

114. At approximately 9.30am on Day 2, RN C performed a nursing review of Ms A when the HCAs alerted her that Ms A appeared to be in pain. However, RN C did not document her review in Ms A's record until 6.00pm. In addition, RN C provided HDC with more information about the review that was not documented at the time, such as Ms A's pain score of 9 out of 10, and that RN C asked Ms A several times whether she had fallen, and Ms A did not answer.

115. In addition, Ms G twice documented the same note about performing Ms A's care — first at 9.34am in the personal care chart, and secondly at 2.50pm in the progress notes. It is unclear which timing is correct, and later it was noted that Ms G did not perform these cares herself, and was documenting on behalf of two other HCAs.

116. The external investigator contracted by Radius noted that there was a practice of Radius staff completing notes several hours after completing the tasks, or recording notes of observations that they did not see. The investigator advised that this was an on-going risk that needed to be considered by Radius.

117. At the time of these events, Radius had a policy titled "Clinical Records", which stipulated that every entry in a consumer/patient health record should:

"a) Document each:
- Assessment
- Event
- Visit
- Treatment
- Procedure
- Consultation

b) Be recorded as soon as practicable after an event has occurred …

…

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e) Be factual, consistent, accurate, legible and complete"

118. At the time of these events, Radius also had a policy for "Accident/Incident Event Reporting", which stated:

> "Any employee that identifies an incident should report it by completing an incident form … the incident form should be completed as soon as possible and before the end of the working duty."

119. Radius told HDC that it accepts that there is a lack of information/documentation in respect of this incident, and that an incident form should have been completed. RN C said that she discussed the matter with the Clinical Nurse Manager and "was not encouraged to make a full record of events that day".

120. RN Russell advised:

> "The recording of information that day was a severe departure from the expected standards as good notes including an incident form would have meant that the investigations could have begun on that day with an incident form being referred back to the night staff."

121. It is clear that on numerous occasions, the assessments and events that occurred in the period of Day 1 and Day 2 were not documented, and the entries that were documented were neither timely, accurate, nor complete. I am also very concerned that some staff said that they were documenting notes on behalf of other staff. I consider that these documentation deficiencies reflect a pattern and culture at Elloughton Gardens of staff non-compliance with Radius's policy. It also begs the question as to whether the assessments and events referred to actually occurred. In addition, the insufficiency and inaccuracy of the documentation considerably hindered the subsequent investigations into the care provided to Ms A.

Staff training

122. On the morning of Day 2, RN C was rostered to work in the hospital-level wing consisting of approximately 23 residents requiring hospital-level care. RN C told HDC that she had obtained her nursing qualifications overseas in 2011 and had previously worked as a theatre and surgical nurse, but had had no previous rest-home experience. She had begun her employment at Radius less than three months before the events of this case and stated that she was provided with very little proper orientation before she started work, with no orientation or guidance on Radius's policies or procedures.

123. RN C told HDC that she had had no previous experience with a resident falling, or of transferring a resident to hospital, completing an incident form, accessing after-hours GP care, or any of the documentation requirements.

124. Radius told HDC that as part of RN C's three-month orientation programme she was required to read Radius's policies and procedures. However, RN C was off work with an

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injury for several weeks, and her orientation programme was put on hold. RN C told HDC that she did not complete the orientation booklet until after these events.

125. RN Russell advised:

> "Aged care providers have a prescribed plan of education that providers are required to provide. The orientation programme if it is completed is comprehensive. However, it appears for a variety of reasons — staffing etc that the education was not complete for all staff. This does not meet the requirements for providers."

126. I accept this advice. I acknowledge that some of the skills that were lacking in this case, such as documentation and escalation of care, are basic nursing requirements. I also acknowledge that RN C was away from work for over a month owing to an injury, and so could not complete her orientation, and that this was outside of Radius's control. However, it is clear that there were gaps in RN C's training at the time of these events, and I consider that in the context of her previous role as a theatre nurse and having obtained her qualification overseas, RN C should have completed her orientation at Radius before being rostered on as the only registered nurse in the hospital-level wing.

127. Radius had a responsibility to ensure that its staff were adequately trained to provide care to its residents. Its failure to do so placed its residents at risk, and in this case RN C's inexperience in the rest-home setting and lack of training affected the care provided to Ms A.

Conclusion

128. I acknowledge that following these events Radius Elloughton Gardens underwent a period of statutory management, and subsequently made significant changes that have led to an improved quality of care for its residents. RN Russell advised:

> "In reviewing these changes and the results of the most recent HealthCERT Audit it is evident that the improvements have led to improved quality of care for residents at Elloughton Gardens."

129. I accept RN Russell's advice and consider these changes to be appropriate, and note that a subsequent HealthCERT audit reflects this. In addition, I wish to acknowledge the extensive efforts taken by Radius to investigate the cause and circumstances of Ms A's injuries, which included the engagement of an external investigator.

130. Nonetheless, I consider that at the time of these events, the care provided to Ms A by Radius Elloughton Gardens did not meet the accepted standard of an aged-care provider. It is apparent that there were serious shortfalls in many areas, and that this had a negative impact on the care provided to Ms A.

131. I have referred to several Radius policies to which its staff members failed to adhere. RN Russell advised that at the time of these events, Radius had a comprehensive suite of policies to cover all aspects of operation, and she did not identify any concerns with these

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policies or procedures. However, as this Office has stated previously,[17] inaction and failure by multiple staff to adhere to policies and procedures points towards an environment that does not support and assist staff sufficiently to do what is required of them. As I have also identified above, the training provided to Radius staff in relation to these policies and procedures was inadequate.

132. In summary, I find that Radius did not provide appropriate care and services to Ms A for the following reasons:

a) Ms A suffered serious injuries at Radius Elloughton Gardens, and it is likely that at least one of its staff members was involved. Despite investigations, the circumstances surrounding Ms A's injuries were unable to be ascertained, which reflects a culture that did not support staff to speak up when mistakes occurred.

b) Staff failed to adhere to Radius's policies in the care provided to Ms A after the injuries were discovered.

c) There was a delay in getting Ms A to hospital as per the GP's advice.

d) There was a pattern of poor documentation by its staff members, which hindered the subsequent investigations into the care provided to Ms A, and was indicative of a culture of non-compliance with Radius's policies and expectations.

e) The training provided to its nursing staff was inadequate.

133. These failures meant that Ms A experienced an event that caused her significant injuries and pain and a lengthy delay in accessing treatment for those injuries. For the above reasons, I find that Radius Residential Care Limited failed to provide Ms A with an appropriate standard of care, in breach of Right 4(1)[18] of the Code.

Opinion: RN C — adverse comment

Introduction

134. RN C was the registered nurse working in Ms A's wing of Radius Elloughton Gardens on the day shift on Day 2, from 6.45am to 3.15pm. As discussed above, there is no evidence that RN C had received sufficient training to enable her to provide appropriate care to Radius residents in line with Radius's expectations and accepted standards.

135. However, I consider that there is also individual accountability for the care provided to Ms A. RN C had been a registered nurse since 2011 — seven years at the time of these events — and the importance of documentation and escalation of care should have been known to her.

[17] See Opinions 16HDC01380 and 19HDC01030.

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

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Care provided to Ms A

Escalation of care

136. RN C said that at the start of her shift she overheard a conversation between the two night HCAs about a fall that had occurred overnight. She was not informed specifically that Ms A had had a fall. The two night HCAs denied that this conversation occurred.

137. RN C was first alerted to Ms A's injuries at approximately 9.30am, when the caregivers informed her that there was something "unusual" about Ms A, and asked RN C to review her.

138. RN C stated that when she attended, Ms A was "screaming and yelling because of [the] pain", and would not let RN C touch her. RN C told HDC that she then tried to undertake a head-to-toe assessment as thoroughly as she could. She stated that Ms A indicated that she had pain and redness on her right upper arm, and that the pain score was 9 out of 10. RN C also stated that Ms A complained of pain (5 out of 10) in both legs, and could bend both knees around 35 degrees. RN C did not document her pain assessment of Ms A. She gave Ms A codeine to relieve the pain, and it was noted that this was not effective.

139. RN C then rang and faxed a request for the after-hours GP to review Ms A, and was told that he would attend at approximately 12pm. Dr H attended Radius Elloughton Gardens sometime between 12.45pm and 1pm. Dr H told HDC that he advised the nurses that Ms A needed to go to Accident and Emergency "immediately" for X-rays and further assessment, and this was documented in the progress notes.

140. RN C did not request an ambulance for Ms A until 2.27pm, and told HDC that this was her first opportunity to call an ambulance after the doctor left. RN C said that she was occupied with another patient, and thought that she needed to have permission from the Clinical Nurse Manager to transfer a resident to hospital.

141. RN Russell outlined the following critical points about RN C's actions on Day 2:

a) RN C said that she overheard a discussion about a fall, but she did not question this or seek an incident report.

b) RN C's assessment of Ms A (including Ms A screaming in pain and indicating a pain score of 9/10), and the fact that codeine was not effective, should have led RN C to seek advice regarding Ms A more urgently.

142. RN Russell stated:

> "[RN C] undertook a basic assessment, as [Ms A] called out and was in pain [and] the assessment was referred by [Ms A] to the out of hours GP. This leads to whether the transfer to hospital was timely and given that [Ms A] had a fractured tibia and fibula meant that she underwent hours of extra pain and discomfort and was at risk from further complications of breaking a bone. The results of [RN C's] assessment should

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have indicated a greater problem and the risk of taking the time to wait on the GP was that they could have come much later in the day."

143. RN C told HDC:

"[D]uring the morning when [Ms A] was sitting in her room … she did not seem in pain. If [Ms A] had been reporting to me that she was in pain, I would have rung the [Clinical Nurse Manager] and if I couldn't speak to her, taken steps to send [Ms A] to hospital straight away, rather than call the GP to review."

144. RN C's statement is contrary to her description to HDC of her observations at 9.30am and following administration of codeine. I accept RN Russell's advice and consider that there were several red flags that should have prompted more urgent action by RN C. Ms A's injuries were first discovered at approximately 9.30am, and the GP reviewed her at around 12.45–1pm. Despite the GP's advice for Ms A to be transferred to hospital, an ambulance was not called until around 2.30pm (1.5 hours later). In my view, RN C should have thought critically about Ms A's situation and recognised that Ms A needed urgent medical attention. Whilst this delay may not have affected Ms A's subsequent outcome, the delay meant that Ms A suffered a prolonged period of pain that could have been avoided with earlier transfer to tertiary care.

Neurological assessments

145. As noted above, after RN C reviewed Ms A, she was under the impression that Ms A had fallen. RN C documented in the progress notes that Ms A had had a fall, and also told the GP that she thought it likely that Ms A had had a fall.

146. Radius's "Falls Assessment and Intervention" policy stipulated:

"• Following a fall, clients require close monitoring and observation. Ensure vital signs are monitored and documented. If the client sustained trauma to the head, or the fall is unwitnessed, the client must be monitored.

• The neurological records should be taken hourly for the first four hours and if stable four hourly for 48 hours … All neurological observations should be done in conjunction with the resident's vital signs, pulse, B/P, respiratory rate and temperature. These are to be recorded on the neurological observation chart and the TPR chart."

147. There is no evidence that RN C undertook hourly neurological observations of Ms A as per the policy, and I am critical of this omission. Ms A's apparent fall was unwitnessed, and therefore it was unknown whether she had sustained trauma to the head. In my opinion, this should have further highlighted to RN C the importance of conducting continued neurological observations.

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Documentation

148. RN C told HDC that at around 9.30am she performed a pain assessment, and Ms A had a pain score of 9 out of 10. RN C stated that she asked Ms A several times whether she had fallen, and Ms A did not answer. RN C also said that after the GP review she checked on Ms A frequently. However, RN C documented notes about Ms A only once on this day, at 6pm (more than eight hours after the assessment occurred), and did not document Ms A's pain assessment.

149. RN C told HDC that as she was trying to do her best for both residents (Ms A and the resident with a blocked catheter), she had no time to complete the progress notes, and had not stopped all day. RN C stated:

> "The notes do not reflect everything that happened, and I accept that my documentation does not reflect all of the relevant information and should have been a better record."

150. Radius's policy for "Clinical Records" stipulated that every entry in a patient health record should "be recorded as soon as practicable after an event has occurred" and "be factual, consistent, accurate, legible and complete". In addition, the Nursing Council of New Zealand Code of Conduct for Nurses states that nurses must "[k]eep clear and accurate records". Furthermore, the New Zealand Nurses Organisation Standards of Professional Nursing Practice states that nurses must "provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate".

151. I acknowledge that RN C was busy, and said that she was not advised of the importance of making a detailed entry in the progress notes. However, I am critical that RN C's documentation on Day 2 did not meet the standards required, including the professional standards as a registered nurse.

152. No incident form was completed regarding Ms A's injuries. RN Russell advised that it would have been RN C's responsibility to follow up with the night nurse to ensure that one was completed. I accept this advice. Whilst the incident that caused Ms A's injuries did not occur on RN C's shift, she was the first registered nurse to discover that Ms A was in significant pain on Day 2. RN C documented that Ms A told her that she had had a fall and, as RN C had not received any information about a fall at handover, she should have completed the appropriate documentation.

Conclusion

153. In summary, I am critical of the care that RN C provided to Ms A on Day 2 following the discovery of Ms A's injuries, and of the poor standard of documentation.

154. Initially, RN Russell was very critical of the care provided by RN C. As noted above, I have found that the training provided to RN C by Radius was not appropriate given that this was her first nursing role in a rest home, and that her orientation was incomplete. RN C had

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only recently started working at Radius Elloughton Gardens. RN Russell subsequently advised:

> "Given this information the seriousness of the departure from the expected level of care has been removed. Given the situation [RN C] found herself in due to her injury and orientation she was not able to [give] the care [Ms A] required … [I]t is evident that, due to an incomplete orientation, limited on call support, and that [RN C] had worked a very short period of time at Elloughton Gardens, she was not adequately prepared to work in this complex situation."

155. I accept this advice. Whilst I am nevertheless concerned about aspects of the care that RN C provided to Ms A, as outlined above, I consider that the failure by RN C was largely caused by the lack of adequate systems in place at Radius Elloughton Gardens to provide appropriate support and training to RN C. As a consequence, RN C was not sufficiently confident or prepared to deal with Ms A's situation.

Recommendations

156. I acknowledge that Radius Residential Care Limited has made significant changes following these events, and I also note that HealthCERT's audit on October 2019 showed that Radius Elloughton Gardens had fully attained all the required standards. Nevertheless, in light of this complaint and the findings made, I recommend that Radius Residential Care Limited (trading as Radius Elloughton Gardens):

a) Undertake a review of all current individual staff training records to ensure that the records are complete and demonstrate that all staff are trained and educated to meet contractual requirements and industry expectations. If a staff member is found not to have received recent relevant training and education, evidence is to be provided to HDC that they have since undertaken, or are enrolled in, the relevant training or education session. Evidence that this has been done is to be sent to HDC within six months of the date of this report.

b) Conduct random audits of staff compliance with the following policies for 15 patients at Radius Elloughton Gardens during the three months preceding the date of my final report:

   i. Documentation policy;

   ii. Falls policy; and

   iii. Adverse event management policy.

   The results of the audits are to be reported to HDC within six months of the date of this report. Where the audit results do not show 100% compliance, Radius is to advise what further steps will be taken to address the issue.

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c) Prepare educational sessions for training its staff (and to include in staff orientation packs) at Radius Elloughton Gardens regarding open disclosure, adverse event management, and documentation. Evidence that this has been done is to be sent to HDC within three months of the date of this report.

d) Undertake meetings with staff and management to discuss the apparent practice of its staff spending time in other wings during their shifts, completing notes hours after completing tasks, and recording notes of observations that they did not see. After the meetings have taken place, Radius is to report back to HDC on the actions it will be taking to address these issues, within three months of the date of this report.

e) Provide HDC with an update on its consideration of the external investigator's recommendation that CCTV be installed to increase security, within one month of the date of this report.

f) Use an anonymised version of this report as a basis for staff training at Radius Elloughton Gardens, focusing on the breach of the Code identified. Evidence that this training has been completed is to be sent to HDC within six months of the date this report.

g) Consider whether any of the learnings from this investigation can be translated into improvements throughout Radius Residential Care Limited's other aged-care services, and report back to HDC on its consideration within one month of the date of this report.

h) Provide Ms A's family with an apology for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

157. I recommend that RN C:

a) Undertake further training on falls and escalation of care. Evidence that this has been done is to be sent to HDC within six months of the date of this report.

b) Provide a written apology to Ms A's family for the criticism made in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

Follow-up actions

158. Radius Residential Care Limited will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

159. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Radius Residential Care Limited (trading as Radius Elloughton

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Gardens), will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

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

Addendum

161. The Director of Proceedings filed proceedings by consent against Radius Residential Care Limited in the Human Rights Review Tribunal. The Tribunal issued a declaration that Radius breached Right 4(1) of the Code by failing to provide services to Ms A with reasonable care and skill.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Julia Russell:

"This report is to consider whether the care provided to [Ms A] was reasonable on [Day 2]. There are two specific questions this report will address:

1. Whether the assessment of her injuries on [Day 2] was adequate.
2. Whether the transfer to hospital was timely and was the associated documentation on [Day 2] adequate.

In considering these questions it is necessary to consider whether the standard of care is acceptable and if there has been a departure from the expected standard of care provided in an aged care environment. Documents reviewed in this report included: the Elloughton Gardens care plan and associated e case notes, fluid balance chart, health care procedure charts, personal care charts, relevant policies and procedures: falls assessment and intervention, [the] District Health Board emergency department admission and in patient notes, [the medical centre] Doctor's note, interRAI assessments, [lawyer's] Review, Corporate Risks Review with some staff interviews and associated documents and Elloughton Gardens' internal investigation associated with this.

Background

[Ms A] had lived at Elloughton Gardens since [2017]. [Ms A] had several co morbidities including cardiac disease, chronic renal failure, anaemia, osteoarthritis and bi-polar disorder. At the time of her injuries she was dependent on health care assistants (HCAs) to get in and out of bed and would not have been able to get up and return to her bed independently; if she had injured herself she would have called out as she did frequently and this would have been heard around the area. Information regarding [Ms A's] dependence was gathered from the staff interviews undertaken as part of the investigation as the care plan was provided and was extensive but was last updated [in late 2017]. There should have been an update in [mid] 2018. As the result of an unknown incident on [Day 2] she sustained a dislocated right shoulder and fractured left tibia and fibula. [Ms A] was seen by the weekend GP and transferred to [the public hospital]. She returned to Elloughton Gardens having had her shoulder re located with a plaster cast on her left leg.

At the time of her fall [Ms A] was understood to have named an Elloughton Gardens staff member as the reason for/associated with it, this staff member is no longer in New Zealand. This complaint has been brought by [Ms A's] niece [Ms B], as she felt despite numerous meetings and communications that Radius Elloughton Gardens has not provided her with the information she seeks to fully understand how [Ms A] was injured and the immediate treatment that occurred.

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Response to questions

1. Was the assessment of her injuries on [Day 2] adequate?

The information provided by [RN C] is an email dated July 2019. It is unclear when information was sought from [RN C] who starts her email apologising for the delay in replying. The timeline provided states [RN C] heard two HCAs discussing that [Ms A] had had a fall at 7:15am. [RN C] was the RN in charge — did [Ms A's] assessment, arranged her transfer to hospital, and spoke with the doctor — Dr H.

There are several critical points that occurred on [Day 2]:

a. 7:15am there is a discussion about a fall which [RN C] overhears but does not question or seek an incident report. It is unknown if [RN C] was on shift on [Day 3] to have followed this up with the night RN or be able to follow up with the Facility Manager.
b. The assessment is undertaken by [RN C] at 9:15am. The results of her assessment should have led her to be very concerned regarding [Ms A]:
   - A 9/10 in a pain score,
   - [Ms A] didn't answer her when she asked if she had fallen — [RN C] had heard she had had a fall, there is no explanation for her fall/no incident form
   - [Ms A] was unusually frightened when touched, so she was unable to do a complete assessment,
   - When given codeine phosphate [Ms A] gets no benefit from this

These points should have led her to seek more urgent advice regarding [Ms A's] situation — discuss it with a colleague or the oncall person.

[RN C] undertook a basic assessment, as [Ms A] called out and was in pain [and] the assessment was referred by [RN C] to the out of hours GP. This leads to whether the transfer to hospital was timely and given that [Ms A] had a fractured tibia and fibula meant that she underwent hours of extra pain and discomfort and was at risk from further complications of breaking a bone. The results of [RN C's] assessment should have indicated a greater problem and the risk of taking the time to wait on the GP was that they could have come much later in the day. [Dr H] did not have all the information and therefore that assessment was not complete. This is a severe departure from the standards of care expected.

2. Documentation on [Day 2]

There was no incident form completed regarding [Ms A's] injuries; ensuring one was completed would be the responsibility of [RN C] to follow up with the night RN as she had heard two night carers discussing a fall. Page 6 of the March 2019 Corporate Risks report paragraph 4.5 states — [Ms A] could not move her legs and the HCAs were advised not to move her by [RN C]. [RN C] states the HCAs did not hear her asking them not to move [Ms A] off the bed as later that morning [Ms A] was in a chair. [RN

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C] reflects that she should have spoken to the HCAs at that point but didn't as the GP would come soon. [RN C] refers to an after-hours GP list which means there may have only been [Ms A's] name written with little or no information regarding what the concern was as she would have expected to speak to the GP when he came. [RN C] had no conversation with the Doctor so he would have only had whatever she wrote on the list to guide him in his assessment and [Ms A] may not have spoken to him.

The daily notes do not clearly tell what happened. [RN C's] notes on [Day 2] say [Ms A] said she had had a fall in the early morning, [but] there is no indication of follow up of the incident at all. The HCA who wrote her notes at 2:50pm had no direct contact with [Ms A] that day so should not have written the notes. [The HCA] should have written [Ms A's] notes as she was with her and undertook her cares that morning.

The recording of information that day was a severe departure from the expected standards as good notes including an incident form would have meant that the investigation could have begun on that day with an incident form being referred back to the night staff. Having an incident form would also have enabled the Facility Manager to have been aware of it rather than being informed by family.

In conclusion the assessment of [Ms A's] injury and the associated documentation are both severe departures from the expected standards provided in aged care environment.

End of report

Julia Russell, RN MPhil (Nursing)"

The following further advice was received from RN Julia Russell:

"The purpose of this report is to provide further advice regarding [Ms A] (dec) who was formerly a resident at Radius Elloughton Gardens.

The documents used in this review included:

1. Response from [lawyer] (acting for Radius Residential Care) dated 28 February 2020 and attachments.
2. [RN C's] response dated 23 July 2020.
3. Statement from [Dr H] dated 12 February 2020.
4. Relevant policies and procedures (both at the time of events and updated).
5. Timeline of events including staff rostering information for [Day 1] and [Day 2].
6. Rosters for [the time of these events].
7. [RN C's] CV and reference checks

Background

[Ms A] had been a resident at Radius Elloughton Gardens since [2017]. [Ms A] had complex needs with a clinical history of cardiac disease, bipolar disorder, chronic renal

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impairment, anaemia and osteoarthritis. On [Day 2], [Ms A] had an unwitnessed fall at Radius Elloughton Gardens and was admitted to [the public hospital] on the same day with a dislocated right shoulder and fractured left tibia and fibula. She returned to Radius Elloughton Gardens' care on [Day 8] and died [a few days later].

In reviewing the further material provided the following matters were considered:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

This report considers:

1. Whether [RN C's] response dated 23 July 2020 changes any aspects of your initial advice, and/or whether you have any other comments in respect of the care [RN C] provided to [Ms A] on [Day 2].

[RN C] completed her bachelor and master's qualifications [overseas] working in theatre and medical surgical areas. In 2018 she came to New Zealand (NZ) and completed an eight-week competency assessment programme (CAP) to become a NZ registered nurse which included a practical element undertaken in an aged care hospital. When she was interviewed for a position at Elloughton Gardens she felt she had stated that her previous experience was not in an aged care environment. [RN C] had been employed at Elloughton Gardens for three months at the time of this incident.

In reviewing [RN C's] two emailed references from her CAP programme these references expressed their support of her as a NZ registered nurse and specifically noted her as competent and would ask questions if she did not understand something and had good communication skills. The referees were advised that she would be an RN in an 86-bed facility — however, there was no information provided to the referees regarding the size of the team she would be working in. Had this information been included the referees may have been able to comment on how she would manage being in charge of an area and manage a group of staff.

In her comprehensive response [RN C] is critical of the role that she found herself in at Elloughton Gardens, stating she had little or proper orientation, felt she was learning on the job; she felt over worked, she requested extra orientation but this was declined due to staffing shortages. She did not have a good understanding of the documentation system as she was not fully trained in it nor did she understand policy and procedure at the start of her employment. [RN C] had not completed her orientation package, when this incident occurred. The orientation package was not completed until Elloughton Gardens was under statutory management (after this

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complaint occurred) and [RN C] had not seen it until it was provided as part of this complaint. This means she did not see the feedback provided by the Clinical Nurse Manager. As well as these concerns [RN C] had sustained [an] injury two–three weeks after starting work at Elloughton Gardens; she was then off work, returning three weeks prior to this incident.

On the morning of [Ms A's] injury [RN C] notes she called the GP practice for advice four times and that a fax to the practice would support that — unfortunately this fax has not been included. [RN C's] response also states she was not in the room when [Ms A] was dressed which a number of the care staff stated she was. Had she been in the room with [Ms A] she would have had further opportunities to assess [Ms A].

The 4 November 2019 report notes that the deficiencies in [RN C's] documentation, assessment and communicating with the GP as serious departures from the expectations of care provided to [Ms A]. Given the comprehensive explanations provided by [RN C] regarding the support she sought to assist, the actual length of work experience at Elloughton Gardens — five weeks in total — and the gaps in the orientation she had received, the concerns regarding the management of Elloughton Gardens [and] the issues [and] deficits that led to the situation were [rooted] in the systems running at Elloughton Gardens. As [RN C] notes with the benefit of hindsight she should have sought more support/orientation, however her ability to stay in New Zealand relied upon having a position — this means she would be less likely to push for more assistance.

Given this information the seriousness of the departure from the expected level of care has been removed. Given the situation [RN C] found herself in due to her injury and orientation she was not able to [provide] the care [Ms A] required.

2. The adequacy of the staffing levels at Radius Elloughton Gardens on [Day 1] and [Day 2].

The 28 February 2020 letter from [the lawyer] states in paragraph 30 that staff levels now meet the Ministry of Health SSI guidelines which may suggest that they did not think they were sufficient at the time of this incident. It is presumed that these refer to the safe staffing guidelines which are a 2010 document.

There are no mandated staffing requirements for aged care. Each facility has their own policies and processes to determine the staffing levels. Also staffing levels are contingent on the acuity/frailty of the residents and the knowledge and experience of the staff. There is no information provided regarding occupancy; therefore these assumptions are based on full occupancy of 86. The short morning — four-hour shift … was not worked on the [week of these events]. Given the information in this file it is not possible to know if this was because there was a lower occupancy and therefore the shift was not replaced. Therefore, it is only possible to give an opinion regarding staffing levels. To assist in giving a view of the adequacy of staffing hours and roster D Cookson's 2017 Mandated nursing staff to resident ratios in aged care: Summary of

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evidence. Wellington: New Zealand Nurses Organisation was used. The Radius Elloughton Gardens staffing numbers per week are in excess of the recommended number of hours per week in the above document.

3. The adequacy of the training provided to staff (including [RN C]) by Radius Elloughton Gardens at the time of these events.

Aged care providers have a prescribed plan of education that providers are required to provide. The orientation programme if it is completed is comprehensive. However, it appears for a variety of reasons — staffing etc — that the education was not complete for all staff. This does not meet the requirements for providers.

4. The adequacy of the relevant policies and procedures in place at Radius Elloughton Gardens at the time of the events.

Radius Elloughton Gardens has a comprehensive suite of policies to cover all aspects of operation. Reviews of policy related to practice often find areas of improvement and as noted in point 5 there were areas that were improved in the policy updates. Given that [RN C] states she was not familiar with all areas of policy and procedure if those improvements had been present it would not have assisted the care and support of [Ms A].

5. The adequacy of the relevant policies and procedures in place at Radius Elloughton Gardens that have been updated since these events.

As an organisation Radius reviews and updates policies not only when required in policy but also as a result of changes that occur.

Some of these policies have not substantively changed with the exception of the Verbal Communication Section 10 of the Clinical Records Policy & Procedure; these changes require verbal communication at handover, and family communication to be recorded on a specific Family Communication Record. The Transfer Form has also been simplified but had a tick box added to record if the resident is having neurological recording done. There have been additions to the Policy which have increased the actions required when an incident does occur. These changes will assist the RNs and Carers who use them to understand what is required of them and improve the care provided to residents.

6. The adequacy of the changes made at Radius Elloughton Gardens since these events.

There have been significant changes made at Radius Elloughton Gardens since this complaint occurred. These included:

- Admissions being closed for eight weeks. During this time there was a full review of staff, management and leadership. There was additional training provided to staff including escalation of adverse event reporting, communication and cultural diversity.

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- A three-month work plan was developed for the clinical nurse manager which included training and working with an experienced external clinical manager. The focus of this plan was risk management, assessment, clinical nurse routines and coaching/management skills.
- Registered nurses have undergone training on managing acute risks and needs, supporting patient safety, understanding and painting the clinical picture, how best to communicate with general practitioners.
- Registered nurses are now working as a team to complete care plans and a benchmarking programme has been established between the registered nurses to monitor falls, rates of injuries with falls, complaints and compliments.
- Documents reviewed

Elloughton Gardens found itself in a period of statutory management following this complaint. In reviewing these changes and the results of the most recent Healthcert Audit it is evident that the improvements have led to improved quality of care for residents at Elloughton Gardens. These improvements included the education programme following this incident which addressed the areas that were found to be deficient.

In conclusion this report has considered [RN C's] 29 July 2020 response and the [lawyer's] 28 February 2020 letter and whether the previous determination of a serious departure from the expected standards is maintained. Given [RN C's] comprehensive response and explanation it is evident that due to an incomplete orientation and limited on call support and that [RN C] had worked a very short period of time at Elloughton Gardens, she was not adequately prepared to work in this complex situation. Therefore this previously severe departure has been reduced to no departure by [RN C].

However, this remains a serious situation as the resident involved was seriously injured and died as a result of this incident. From all the material provided and the [lawyer's] letter it appears there were significant system issues present at Elloughton Gardens at the time of this incident and that the actions taken as part of the statutory management has addressed the issues. Despite this at the time of the incident Radius Elloughton Gardens did not meet the expected standards of an aged care provider and this was a serious departure from the standards.

End of report

Julia Russell, RN MPhil(Nursing)"

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