Radius Residential Care Limited

Registered Nurse, RN C

Clinical Nurse Manager, CNM D

Registered Nurse, RN E

A Report by the Deputy Health and Disability Commissioner

(Case 16HDC00099)

Table of contents

Executive summary 1

Complaint and investigation 3

Information gathered during investigation 3

Opinion: Radius Residential Care Ltd — breach 14

Opinion: RN E — breach 18

Opinion: RN C — breach 20

Opinion: CNM D — other comment 22

Recommendations 23

Follow-up actions 24

Addendum 24

Appendix A: Independent advice to the Commissioner 25

Executive summary

1. Mr B (aged 80 years) suffered from multiple health problems including Alzheimer's dementia with delirium. On 21 December 2015, Mr B was admitted to the psychogeriatric unit of a rest home for a two-week period of respite care. The rest home is owned and operated by Radius Residential Care Ltd (Radius). Mr B's stay involved periods of unsettledness, which included challenging behaviour, agitation, and refusing medication and cares. At the time of these events, a registered nurse (RN) RN C was the Facility Manager and CNM D was the Clinical Nurse Manager (CNM); they were both offsite for much of Mr B's stay. RN E was the Restraint Coordinator. A number of issues were identified regarding Mr B's admission:

- Mr B had appointed his wife as his enduring power of attorney, but this was not activated. Mrs B was asked to consent on Mr B's behalf.
- Mrs B was asked to sign a "do not resuscitate" (DNR) order on Mr B's behalf.
- On admission, information about Mr B was not requested from the family, and it is not evident that staff were orientated in the particular challenges Mr B might present during his respite period.
- Mr B was restrained with a lap belt for several hours on ten occasions over nine days by different rest home staff. Documentation of the restraint and consent was not completed adequately or in accordance with Radius policy.
- Despite conflicting prescription and blister packing of medication, Mr B's quetiapine prescription was not queried with his GP on admission, and his GP was not contacted to review Mr B's medication regimen when medications were withheld owing to his changing condition (ie, when he was sleepy and unsteady).
- Mr B's diabetes was not monitored during his admission, and when Mr B was not eating, there was not a systematic evaluation of the reasons for this.
- Personal care, particularly regarding oral care and showering, was lacking.
- Mr B was manually assisted to make a bowel motion when this was not clinically indicated or consented to.
- There was not suitable senior staffing oversight over the holiday period.

Findings

2. Radius had the ultimate responsibility to ensure that Mr B received care that was of an appropriate standard and complied with the Code. The Deputy Commissioner considered that the following deficiencies are apparent in the care Mr B received from Radius:

- Restraint policy and procedure were not followed;
- Mr B's medication regimen was not reviewed in light of his deteriorating condition or prescription;
- Mr B's diabetes was not monitored;
- An evaluation of the reasons for Mr B not eating was not undertaken;
- Personal cares for Mr B were lacking;
- Mr B's legal status was not clarified; and
- Mrs B was asked to sign a DNR order on Mr B's behalf.

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3. Overall, the Deputy Commissioner did not consider that the care provided to Mr B by Radius was adequate. Accordingly, it was found that Radius Residential Care Ltd did not provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[1]

4. RN E had a responsibility to ensure that Mr B received care that complied with the Code. The Deputy Commissioner was critical that in his role as Restraint Coordinator, RN E allowed restraint to be applied to Mr B in a manner that did not comply with Radius policy, and that RN E allowed an invasive procedure to be performed by a healthcare assistant without clinical indication. It was found that RN E did not provide services to Mr B with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

5. The Deputy Commissioner was not satisfied that Mr B gave informed consent to the use of restraint or the anal massage/manual evacuation, or, if he was not competent to consent and in the absence of anyone being available to consent on his behalf, that his family were not consulted. Accordingly, it was found that RN E breached Right 7(1) of the Code.[2]

6. As Facility Manager, RN C had a responsibility to provide an appropriate standard of care to Mr B, even though she was not physically on site for much of his stay. It was found that the admission process undertaken by RN C for Mr B was suboptimal, and there was not adequate senior staffing oversight during the respite period. Accordingly, it was found that RN C did not provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code.

7. The Deputy Commissioner made other comment about the care provided to Mr B by CNM D.

Recommendations

8. In the provisional opinion, it was recommended that Radius Residential Care Ltd provide further training for all rest home staff on the NZS 8134.2.2008 Health and Disability Service Standard (restraint and minimisation and safe practice standards); undertake an audit of the restraint use consent forms; undertake a review of its processes in relation to respite assessment and care planning, documentation, medication management, and management of complex conditions; undertake a review of the staffing levels and skill base at the rest home; update the client-initiated resuscitation form; update the resident register documentation; provide an update on the work that has been undertaken with the District Health Board to ensure that service provision requirements have been met; and provide a written apology to Mr B's family. Radius confirmed that it had met or would meet these recommendations.

9. It was recommended that RN E undertake training on informed consent and restraint minimisation and safe practice standards, and provide a written apology to Mr B's family.

[1] Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.

[2] Right 7(1) of the Code states that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent.

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10. It was recommended that RN C provide a written apology to Mr B's family.

Complaint and investigation

11. The Commissioner received a complaint from Ms A about the services provided to her late father, Mr B, at the rest home. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr B by Radius Residential Care Limited.*
- *The appropriateness of the care provided to Mr B by Facility Manager RN C.*
- *The appropriateness of the care provided to Mr B by Clinical Nurse Manager CNM D.*
- *The appropriateness of the care provided to Mr B by Registered Nurse RN E.*

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

13. The parties directly involved in the investigation were:

Ms A	Complainant
Mrs B	Consumer's wife
Radius Residential Care Limited	Provider
RN C	Facility manager
CNM D	Clinical nurse manager
RN E	Registered nurse

14. Also mentioned in this report:

Ms G	Regional manager
RN H	Registered nurse

15. Information from the District Health Board, general practitioner (GP) Dr F, and the pharmacy was also reviewed.

16. Independent expert advice was obtained from a registered nurse, Jan Grant (**Appendix A**).

Information gathered during investigation

Background

17. Mr B (aged 80 years at the time of events) was cared for by his wife, Mrs B, and home care support workers. Mr B suffered from multiple health problems including Alzheimer's dementia with delirium. Mr B had executed an enduring power of attorney (EPA) for personal care and welfare that appointed Mrs B as his attorney. An EPA is a legal document

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that gives someone else the authority to act for a person if he or she is no longer able to make decisions for him- or herself. In May 2015, Mr B's general practitioner (GP) confirmed that in light of Mr B's medical condition, it was appropriate for the EPA to be invoked; however, the EPA was not activated.[3]

18. Mr B was on the District Health Board's (the DHB's) respite care programme. In the past, this care had been provided by a local rest home facility. However, in November 2015 he was reassessed as requiring his respite care in a psychogeriatric hospital setting.

19. On 21 December 2015, Mr B was admitted to the rest home for a two-week period of respite care. He was discharged on 4 January 2016. Mr B's stay involved periods of unsettledness, which included challenging behaviour, agitation, and refusing medication and cares. Sadly, Mr B died of hypernatraemia[4] and dehydration, within a month of discharge.

20. It is acknowledged that this report does not cover every discrete issue raised by Mr B's family. This report concerns the standard of care provided to Mr B during the two-week respite period at the rest home, and covers the key issues identified by the Deputy Commissioner.

The rest home

21. The rest home is owned and operated by Radius Residential Care Ltd (Radius). The rest home provides hospital-level, rest-home level, and psychogeriatric care.

22. Rosters provided by Radius show that there was a registered nurse and healthcare assistants (HCAs) rostered on each shift during Mr B's stay; on occasion the nurses were from a bureau. RN E was the registered nurse rostered on duty during 10 of the days of Mr B's admission.

23. At the time of these events, RN C was the Facility Manager at the rest home. The Facility Manager's job description listed the purpose of the job as: "To manage staff and resources to ensure the delivery of safe and effective, quality life and health care services are provided to all residents within the facility." Key activities in RN C's role included leadership and management, marketing, occupancy management, risk management, people management, quality, health and safety, and staff rostering. RN C was to report to the Radius Regional Manager, Ms G. RN C was not on site at the rest home for eight days of Mr B's admission.

24. CNM D was the Clinical Nurse Manager. The CNM job description listed the purpose of the job as: "To manage staff and resources ensuring safe and effective professional quality care services are provided to all residents within the facility." Key activities in CNM D's role included clinical leadership, reporting requirements, and quality and people management. CNM D was to report to RN C. CNM D was not on site at the rest home for nine days of Mr B's admission.

[3] That is, the required medical certificate certifying that Mr B was mentally incapable had not been signed.
[4] High concentration of sodium in the blood.

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Pre-admission

25. On 13 November 2015, a DHB gerontology nurse specialist faxed an admission enquiry to the rest home for Mr B, including a letter from a psychiatrist to Mr B's GP, Dr F, dated 13 November 2015. This set out Mr B's current diagnosis of Alzheimer's dementia, with late onset and delirium, and explained issues he was having at his current respite facility and his need for secure psychogeriatric respite care. The faxed information also included a clinical nursing review dated 12 October 2015. The clinical nursing review set out Mr B's medical history, medications, recent investigations, social history, functional abilities, and a summary of his condition.

26. RN C stated that she gave the admission date and medical history to CNM D and asked her to make contact with Mr B's family and doctor prior to Mr B's admission. CNM D stated that she spoke briefly to Mrs B to advise her that there was a room available at the rest home.

27. RN C said that it was her responsibility to complete and prepare documentation relating to pre-admission enquiries. RN C sent a brief email to Mr B's daughter explaining that he would need to bring clothing, toiletries, and medication. While there was a pre-admission form available for use, RN C did not send this to the family, and no further information about Mr B was requested.

28. RN C stated that she accepts responsibility for not going through a thorough process of pre-admission with Mrs B, and acknowledges that a good respite information package would have been of benefit to the family.

29. RN C welcomed Mr B to the psychogeriatric unit on 21 December 2015 when he was admitted, and introduced him to staff. There is no evidence from the clinical records or responses provided to HDC that the psychogeriatric unit staff were orientated to the particular challenges Mr B might present during his respite period.

30. In Mr B's resident register documentation, it is recorded that there was an EPA for personal care and welfare, and that Mrs B was the appointed attorney under this. There is no copy of the EPA in the clinical records, and no evidence that the rest home sighted the documents, enquired about activation, or sought to sight the necessary medical certificate.

Use of restraint

31. The Radius Clinical Manual — Restraint Policy and Procedure policy sets out that residents are to be restrained only as a last resort, to avoid harm to residents or others. It states that restraint can be commenced only after consultation has occurred with at least one other member of the multidisciplinary team and the medical officer. It also states that the Restraint Coordinator is responsible for ensuring compliance with this restraint policy, as well as the New Zealand Health and Disability Services Standards for restraint minimisation and safe practice (NZS 8134.2.2008).

32. It is documented that Mr B was restrained by a lap belt for several hours on ten occasions over nine days by different rest home staff. Periods of restraint were documented in

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different places in Mr B's clinical notes.[5] There is no information in the clinical notes stating that alternatives to restraint were considered.

33. The restraint discussion and consent form outlines the outcomes of the restraint (maintain client's personal safety and safety of other residents in the unit), the method of restraint to be used, and the associated risks. A handwritten entry states that this was discussed with "family & RN on duty". The form records that everyone was in agreement that a restraint trial period should commence, and that they agreed to a lap belt being used for a 30-minute timeframe. RN H documented in the progress notes on 23 December 2015: "[Mrs B] agreed to use PRN lap belt for client's safety and she may come on boxing day to sign the consent." Mrs B told HDC that she was asked about restraint when she visited on Christmas Day. She said that she was told that the rest home had had to restrain Mr B using a lap belt. However, Ms A told HDC that Mrs B gave verbal consent to restrain Mr B with a tilt-back chair.

34. The restraint discussion and consent form requires consent from the client (or client representative), medical officer, registered nurse, and Restraint Coordinator. The form was signed by RN E on 26 December 2015 (as both the registered nurse and the restraint coordinator). The form is not signed by a medical officer, and there is no evidence that a medical officer was consulted. Radius told HDC that RN H, who spoke to Mrs B, wrote Mrs B's name on the consent form in anticipation of her coming to sign it.

35. RN E had been the Restraint Coordinator since January 2015. He said that, as the Restraint Coordinator, he did restraint audits and submitted the results to the CNM, made suggestions regarding the use of restraints during registered nurse meetings, and conducted in-service training about restraints with staff. He said that he always instructed staff to complete restraint forms in the correct way. RN E said that it was the job of the HCAs to complete the restraint use forms.

36. Radius accepts that its restraint policy was not followed by its staff. RN E stated that when he signed Mr B's restraint form, he assumed that RN H had followed policies.

Medication administration

37. The information faxed to the rest home on admission set out Mr B's medications. A letter from the psychiatrist to Dr F listed Mr B's medications as risperidone 0.5mg at noon, 1mg at night, 1.5mg PRN (as needed), and quetiapine 25mg as needed for agitation.

38. The medication order sheet sent from Dr F to the rest home on 23 December 2015 lists risperidone 0.5mg twice daily and quetiapine 25mg three times daily, plus risperidone 0.5mg PRN for agitation.

39. The blister packs provided by the pharmacy included risperidone 0.5mg twice daily (breakfast/lunch). The prescription of quetiapine 25mg three times daily was blister packed

[5] The restraint monitoring form shows the following entries: 24/12/15 from 9pm–12am (on and off), 25/12/15 from 11am–3pm (on and off), 27/12/15 1–3pm, 29/12/15 5.40am–7am, and 3pm–10pm (on and off). The progress notes show the following other occasions on which Mr B was restrained: 26/12/15 11am (however, Mrs B's daughter reports that she visited from 2–3pm and he was still restrained when she left), 30/12/15, 31/12/15, 1/1/16, 2/1/16.

HDC

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as one regular dose (dinner time) and two further PRN doses per day. While it is not apparent from the documentation who provided the instruction to amend the prescription in this way, Dr F stated:

> "[A]s far as I can recall, the additional doses throughout the day were PRN dependent on [Mr B's] degree of agitation. This may well have been conveyed to the pharmacist at the time."

40. Ms A told HDC that, at home, Mr B received quetiapine (25mg) only once daily.

41. The regular administration record and medication administration signing sheet show that Mr B was generally administered quetiapine 25mg at breakfast, lunch, and dinner times during his admission, apart from some occasions when it was withheld.[6] The PRN medication administration signing sheet shows that risperidone 0.5mg was given on three occasions and refused twice.[7] On occasion, administration or withholding of medication was noted in the progress notes but not in the medication charts.

42. One registered nurse stated: "I administered medication per the medication chart. I withheld his psychotropic medication when he seemed to be sleepy as it was PRN medication." On discharge, it was documented in the clinical notes that Mr B was unsteady on his feet and sleepy. Another registered nurse recorded that Mrs B was informed that she should query a review of Mr B's medication, and noted that quetiapine had been charted three times daily, but only one dinner quetiapine was included in the medicine pack.

43. The clinical records do not show that Mr B's medications were reconciled on admission, and there is no evidence that Dr F was contacted to query the doses.

44. Ms A told HDC that the unused PRN risperidone medication was not returned when Mr B was discharged. The rest home stated that it could not determine the whereabouts of the medication, but said that it may have been sent back to the pharmacy. It was found in the DHB investigation (referred to below) that there was no satisfactory explanation for this.

Nutrition and hydration

45. The information provided by the gerontology nurse specialist to the rest home stated that Mr B had type two diabetes. Mr B's medications, which were also included in this information, included metformin and gliclazide, which are used to treat diabetes. On the dietary requirement form in Mr B's clinical records, "diabetic diet" is ticked. However, the respite/short-term care plan states both that Mr B had type two diabetes and that he ate a normal diet.

46. Food/fluid intake charts were commenced on 22 December 2015 and initially state that Mr B was eating well. There is a period from 25 to 29 December 2015 where there are no documented food/fluid intake charts. Ms A told HDC that she advised RN H that her father was not eating or drinking, based on what she had been told by an HCA. RN E said that Mr

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[6] The medication administration signing sheet and non-packaged regular administration record show that this was on five occasions between 31 December 2015 and 3 January 2016.

[7] 22/12/15, 23/12/15, 24/12/15, refused on 25/12/15, 2/1/16.

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B's food/fluid chart was discontinued on the third day of his respite care, but that when his oral intake decreased, the chart was recommenced. RN E stated that he always asked HCAs about patients' oral intake, and would document it according to what he was told. The food/fluid intake charts were recommenced on 30 December 2015 and generally show that Mr B refused meals or ate and drank very little.

47. There is no evidence that Mr B's blood sugar level was monitored at any time during his stay at the rest home, and it is not apparent from the clinical records that the reasons for Mr B's refusal of food were evaluated.

48. The Radius Nutrition and Hydration Clinical Manual — Policy and Procedure states that an individual who continually refuses to eat or drink is at high risk of dehydration and malnutrition, and the appropriateness of artificial feeding support should be discussed and documented by the multidisciplinary team.

49. Ms A told HDC that, on admission, Mrs B provided rest home staff with a tin of Fortisip,[8] advising them to include this in Mr B's diet, but that the unopened tin was returned on his discharge.

Weight loss

50. The clinical nursing review dated 12 October 2015, provided to the rest home by the gerontology nurse specialist, states: "[Mr B] has certainly lost weight. He was 72kg in August last year and is now around 58kg, there is an open referral to the dietician." A community dietician documented that Mr B's weight on 8 December 2015 was 62.9kg.

51. Mrs B and a home support worker weighed Mr B in the week prior to his admission to the rest home, and state that he was 70kg at that time, then 53kg on the same scales the week following his discharge from the rest home.

52. RN E said that on the night of Mr B's admission, he noticed that Mr B's initial weight recording had not been completed, so he handed over to the morning staff to complete this. A weight of 59kg is recorded on the respite/short-term care plan on 22 December 2015. A weight of 59kg is recorded on the weight record sheet on 23 December 2015, and a weight of 57.4kg is recorded on the weight record sheet on 1 January 2016.

53. CNM D said that following Mr B's discharge, she contacted the medical centre and was told that Mr B's last recorded weight was 64kg in April 2015.

54. Mr B was admitted to hospital on 19 January 2016, and was noted to be 50.3kg on admission.

Personal care and hygiene

Showers and teeth cleaning

55. The daily personal cares chart records that Mr B was showered on 24, 25, and 29 December 2015. There are two charts for January 2016, one showing that Mr B was showered only on 4 January 2016, and the other showing that he was showered on 1, 2, and 3 January 2016.

[8] A fortified nutritional drink.

56. The daily personal cares chart shows that Mr B's dentures and teeth were cleaned once daily on 22, 23, 24, 25, and 28 December 2015. The two charts for January 2016 are again conflicting, with one showing that Mr B's teeth were cleaned once on 1 January 2016, and the other showing that they were cleaned once daily on 1, 2, and 3 January 2016.

Oral thrush

57. The day following Mr B's discharge from the rest home, he was diagnosed with oral thrush. Ms A stated that family observed a white coating on Mr B's mouth and tongue on 25 and 26 December 2015, but at the time thought this was Fortisip.[9] There is no information in the clinical records to suggest that nursing or HCA staff were aware that Mr B had oral thrush.

58. RN E cannot recall receiving any reports from HCAs about Mr B having oral thrush, and said he assumed that Mr B was receiving appropriate oral cares. However, RN E later stated that according to other staff, oral cares had not been able to be carried out because of Mr B's increasing aggression.

Bowel management

59. A daily personal care chart was used to record personal cares. The chart includes sections for recording whether Mr B's bowels had opened (am, pm, and night). However, the chart was not completed regularly, and on some days there are no entries in relation to Mr B's bowel habits.[10]

Alleged manual evacuation

60. On 1 January 2016, it was documented in the progress notes that Mr B was constipated and was "helped to moved bowels manually" by two HCAs and a registered nurse (RN E). The progress notes state that Mr B's bowels had opened on the previous day (31 December 2015).

61. In a statement to Radius, RN E said that he responded when he was told by the HCA that Mr B was straining on the toilet. RN E stated that when he observed Mr B, a hard dry stool was seen to be lodged in his anal area. RN E said that he remained with the HCA as the HCA massaged the anal area to enable a bowel movement, which occurred. RN E said that, on reflection, he should not have approved of the HCA's action because this would be considered an invasive action without consent.

62. During a family meeting, Ms A asked RN C about what had happened. Ms A said that RN C left the office to clarify with RN E what had occurred. Ms A stated that RN C then returned and demonstrated with hand actions, at least three or four times, stating that staff had double gloved, used lots of KY jelly, and had inserted two fingers.

63. RN C agrees that she went to clarify with RN E what had happened. However, RN C told HDC that manual evacuation did not occur, and that the HCA had "only massaged [Mr B's] anal area to enable a bowel movement".

[9] A nutritional supplement drink.
[10] 27/12/15, 1/1/16, 2/1/16, 3/1/16.

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Client-initiated resuscitation order

64. On 21 December 2015, Mrs B signed a client-initiated resuscitation order on behalf of Mr B, stating: "[I]n the event of a cardiac arrest … I request that no resuscitation be performed." The form is also signed by another RN.

Further information

CNM D

65. CNM D stated:

> "As the Clinical Nurse Manager I expect that the RN's will report or raise any concerns they may have about a resident in care. None of which was reported to me by the RN team or the family of [Mr B] during his entire stay."

66. CNM D did not work at the rest home between 24–28 December 2015 or between 1–4 January 2016. She said that during most of the days when she was working during Mr B's stay, she worked in the hospital wing.

67. CNM D acknowledged that it was her role to oversee and provide support to the clinical staff, but said that in attempting to fill in and cover the staffing gaps she was not able to complete her role as it ought to have been, or as per her job description. She said that despite her attempts to address the issue with managers and get something done about it, nothing was done and she felt very unsupported, which contributed to why she left the position.

68. CNM D told HDC that it was normal practice for her not to work during statutory holidays and weekends, but that she was available on call. She stated that often she worked between 12- and 15-hour days to keep up with her workload. CNM D noted that the role at the time involved managing approximately 50 staff members and caring for 54 residents. She said that often she stepped in to cover shifts, in particular to ensure that the psychogeriatric unit had registered nurse cover throughout each shift to comply with DHB requirements.

RN C

69. RN C said that no concerns were voiced to her in relation to Mr B's deteriorating health during his stay.

70. RN C stated that she had arranged with CNM D and Ms G that she would be away during eight days of Mr B's stay, and that CNM D would be on call during the statutory holidays, and Ms G would be the second point of call. RN C stated: "[A]ll rosters were covered at the time of [Mr B's] admission and my departure for the [Christmas] period."

71. RN C advised that in the region it is hard to find experienced staff with dementia qualifications, and that the skill mix rostered on would include experienced staff working every shift along with new staff who had completed an orientation programme within three months of their employment commencing.

72. RN C told HDC that her Facility Manager workload meant that often she would work seven days per week.

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73. RN C stated that CNM D used to stay on after her eight-hour shift, but that this was never asked of her at any time. RN C said that this was CNM D's choice, and she used to tell her to go home. RN C also noted that the majority of registered nurses would struggle to finish all of their paperwork in one eight-hour shift.

74. RN C said that should staff members call in sick, she would first try to cover the shift with casual and current staff, before contacting Ms G to consider using bureau staff.

RN E

75. RN E stated that staff shortages were often a problem. He told HDC:

> "It was very hectic working in a psychogeriatric ward with more than 19 patients with inexperienced staff and a lack of skill mix making things worse, especially on afternoon shifts."

76. RN E acknowledged that as a registered nurse he is responsible for ensuring that HCAs have the knowledge and skills to undertake delegated tasks, and, when delegating tasks, for monitoring and evaluating the HCAs' actions.

Radius Residential Care Ltd

77. Radius stated that CNM D and RN C were not rostered to work on public holidays, but that they were responsible for ensuring that a senior clinician was available to provide after-hours cover, including on public holidays. Radius stated that neither RN C nor CNM D was on approved annual leave during the holiday period.

Ms A

78. Ms A stated that Mr B walked into the rest home carrying his own bag and in reasonably good condition given his medical conditions. However, when he left the rest home he was in a wheelchair, unable to weight bear, was drowsy, malnourished and dehydrated, had oral thrush, and was unable to communicate. Ms A provided statements from Mr B's home carers with similar observations of the change in Mr B's condition.

External reviews

79. The DHB conducted an investigation into the care provided to Mr B. The review found that the rest home's registered nursing and direct care staff failed to provide the level of care Mr B required, and did not respond appropriately to his changing healthcare needs. It found that effective clinical governance and supervision during his stay in the psychogeriatric unit was unable to be evidenced.

80. HealthCERT undertook surveillance audits of the rest home in January 2016, October 2016, and August 2017. The August 2017 audit identified some areas where there were standards partially attained and of low risk. In particular, some HCAs working in the psychogeriatric unit had not completed required dementia standards; there were insufficient interRAI-trained registered nurses to meet interRAI assessment contractual timeframes; some residents with whom restraints were used did not have documented restraint assessments; and some hospital resident files had gaps of more than 24 hours where progress notes were not recorded.

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Changes to service

81. The complaint to HDC prompted Radius management to conduct in-service education on a variety of subjects, including assessment and planning (especially for respite clients), restraint management, incident reporting, medication management, management of diabetes and other medical conditions, and wound management.

82. Radius stated that it has worked closely with the DHB to ensure that service provision requirements have been met. Radius said that a senior nurse has been appointed to work in the psychogeriatric unit to provide increased supervision and leadership, and that a new management team has been appointed.

Responses to provisional opinion

83. Responses to relevant sections of the provisional opinion were received from Radius, RN E, and RN C. CNM D was given the opportunity to respond to relevant sections of the provisional opinion, but did not do so. A response to the "information gathered" section was received from Ms A on behalf of Mr B's family. Where appropriate, comments have been incorporated into the "information gathered" section above.

Radius

84. Radius advised that RN C, RN E, and CNM D were fully aware of policies and procedures, and provided evidence of the in-service training record.

85. Radius stated that it does not accept that CNM D was unable to perform the key functions of her role owing to her workload. Radius stated that the tasks CNM D listed as being evidence of her unsustainable workload were all part of a CNM role, and noted that the rosters indicate that the psychogeriatric unit was fully staffed during Mr B's stay.

86. Radius advised that RN E was given training on the Restraint Coordinator role by an experienced facility manager on 20 January 2015.

87. In response to concerns raised by its staff about the staffing mix, Radius told HDC that of the morning staff who were on duty during Mr B's stay, two had formal qualifications in dementia care and all others were completing this training, two had been registered nurses in their home countries, and all staff on the afternoon and night shift were experienced in the psychogeriatric unit. Radius also disputes that HCAs were allocated from the psychogeriatric unit to the hospital wing.

88. Radius stated:

> "It is accepted that Radius has a duty to ensure that its residents are provided with care of a reasonable care and skill. It does this by ensuring that appropriately qualified and trained staff at sufficient levels are employed and supported in their roles."

89. Radius submitted that the deficiencies in care provided to Mr B have all been identified to have been as a direct result of qualified, experienced senior staff failing to comply with Radius policies and to fulfil the responsibilities of their various job descriptions.

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90. Radius also stated that it hopes it is evident from the implementation of many of the proposed recommendations (detailed further below) that it has taken this matter very seriously and has been as proactive as possible to ensure that similar issues do not arise again.

RN E

91. RN E accepts that he should have checked all documentation to ensure that it complied with the restraint policies. However, he also stated that he did not receive proper induction to the Restraint Coordinator role, or senior oversight. RN E noted that he was not given any time over and above his registered nursing duties to ensure that restraint assessment, consent, monitoring, and documentation complied with relevant policies and standards. RN E stated that he was often praised for his Restraint Coordinator role in registered nurse meetings, so assumed that he was doing things correctly. RN E noted that while policy required registered nurse oversight of all restraints, in practice HCAs managed and signed off restraint cares, and this was accepted and common practice at the rest home. He advised that he was never told that the existing practice he was following was not the correct procedure in relation to the policy.

92. RN E provided evidence that during the period 3 December 2015 to 10 January 2016 (during which time Mr B's admission occurred), he worked an extra 40 hours to make up for staff shortages and to ensure that there was a registered nurse rostered during the holiday period. He reiterated that staff shortages, inadequately experienced staff/lack of appropriate skill mix, and challenging patient issues in the psychogeriatric ward impacted on the standard of care he was able to provide during Mr B's admission. RN E stated that if they were short on staff it was routine to reallocate a caregiver from the psychogeriatric unit to the hospital wing, putting strain on resourcing in the psychogeriatric unit, and he would often end up assisting caregivers with cares owing to patient behaviour.

93. RN E undertook to comply with my recommendations.

RN C

94. RN C stated that, in her view, there was senior coverage confirmed while she was away and a good balance of skill mix cover. However, she noted that she had no control over employees ringing in sick, and stated that this used to happen almost on a daily basis. RN C advised that she has reflected on this complaint. She stated that at her current workplace she now uses a checklist system prior to resident admissions, and ensures that all registered nurses have access to residents' historic information and information about current conditions and challenges. RN C stated that she will comply with my recommendation.

Relevant standards

95. The New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008) state that restraint should be used only in the context of good clinical practice and after all less restrictive interventions have been attempted and found to be inappropriate. The Standards state:

> "Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions

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in the care setting, and always in the context of the requirements of this Standard, and currently accepted good practice …

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard."

Opinion: Radius Residential Care Ltd — breach

96. Radius had a duty to provide Mr B with services with reasonable care and skill. This included responsibility for the actions of its staff, and an organisational duty to facilitate continuity of care. Radius also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

"**Service Management Standard 2.2**: The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."

Overall comments

97. There are a number of serious issues with the care provided to Mr B during his short period of respite care at the rest home. These are addressed in turn below. My expert advisor, RN Jan Grant, provided the following overall advice regarding Mr B's care:

"I believe that the notes I have reviewed show that each issue in relation to [Mr B's] stay was treated in isolation to other events, whether it was each shift, or daily, over the time he was at [the rest home]. I believe the notes show that there was no adequate follow up, and no systematic gathering of information for an evaluation of the whole clinical picture of his declining health. They also show a lack of good clinical reasoning by registered staff. It would be expected in practice to evaluate declining health in any client under their care, especially short term clients who decline so quickly.

It is acknowledged that [Mr B] presented challenging behaviours but there was no evidence of medical input or advice sought from appropriate health professionals.

I believe that the standard of care would be viewed as a moderate to severe departure from acceptable standards by my peers."

98. I accept RN Grant's advice and am concerned at the overall standard of care provided to Mr B.

99. I acknowledge the differing accounts from Radius and its nursing staff regarding the level of support and training provided, and the staffing levels and skill mix in the psychogeriatric unit. I accept that Radius had in place appropriate policies and procedures and provided training to its staff on these. However, based on the responses provided independently to HDC, I also accept that individual nursing staff felt that they were time pressured and

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unsupported in their roles. I have identified areas of care that I consider are attributable to individual staff members, and I have commented on these in the relevant opinion sections below. However, there were multiple Radius HCA and registered nursing staff members caring for Mr B during his respite stay. I consider there to have been a pattern of poor care attributable to Radius as the organisation with the overall responsibility for Mr B's care.

Restraint

100. Restraint is a significant matter, and a provider should ensure that consent has been obtained and policies have been complied with before restraining a resident.

101. Mr B was restrained with a lap belt on ten occasions over nine days by various rest home staff. The restraint documentation (the consent form and the restraint monitoring form) was not filled in adequately by rest home staff. The consent form regarding restraint was signed only by RN E, and a medical officer was not consulted. Mrs B's name had been written on the form by RN H, in anticipation of it being signed.

102. RN Grant advised that the Radius Clinical Manual — Restraint Policy and Procedure was not followed, as the consent form was scantly filled in and did not include adequate information or rationale to meet the requirements of the policy, and there is no evidence that a member of the multidisciplinary team (eg, the GP) was consulted. Further, RN Grant considered that the restraint monitoring form was very poorly completed by rest home staff, and there is scant information in the progress notes to show what, if any, alternatives were considered. RN Grant advised:

> "It is my opinion that Restraint Cares were poorly managed, very poorly documented and did not meet the standards in relation to NZS 8134.2.2008 Health and Disability Service Standard (restraint and minimisation and safe practice standards.)
>
> I believe my peers would view this as a severe departure from acceptable standards."

103. I accept this advice, and am highly critical that Mr B was repeatedly restrained without consent being obtained, without alternatives being considered, without consultation with a medical officer, and without adequate documentation of the use of restraint on the restraint monitoring form.

Medication review

104. Mr B's quetiapine prescription was for 25mg three times daily, and the rest home had a copy of this. The pharmacy packed the quetiapine as one daily dose (dinner) plus two further PRN doses. Mr B's medications were not reconciled on admission, and he regularly received quetiapine three times daily at the rest home. However, on occasion, Mr B's quetiapine and risperidone were withheld owing to Mr B being sleepy and unsteady, and withholding of medication was sometimes noted in the progress notes but not on the medication charts. On discharge, Mrs B was advised by the registered nurse to have the medication regimen reviewed. Dr F was not contacted to query the prescription at any time during Mr B's admission.

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105. RN Grant noted that Dr F was not contacted for clarification. She stated: "[I]t appears from my examination of signing sheets, that Mr B received extra medications." RN Grant advised:

> "[Mr B's] condition deteriorated throughout his stay and there is very limited/no evidence that he had a robust assessment of his increasing confusion and poor physical condition throughout his stay. Some of [Mr B's] symptoms, such as his declining mobility, may well have been contributed to by his medication, and this should have been considered as a possible factor in an assessment of his deteriorating condition.
>
> I am of the opinion that medication management was not of an acceptable standard and would be viewed as a moderate–severe departure of acceptable standards by my peers."

106. RN Grant also commented that had Mr B had a medical review in the time he was at the facility, there may well have been changes made to the medication regimen.

107. I accept RN Grant's advice. I am critical that despite the conflicting prescription and blister packing of medication from the pharmacy, Mr B's quetiapine prescription was not queried with his GP on admission. Further, I am concerned that the GP was not contacted to review Mr B's medication regimen when medications were withheld owing to his changing condition (ie, when he was sleepy and unsteady).

Nutrition and weight loss

108. Mr B had type two diabetes. His clinical records state both that he ate a diabetic diet, and that he ate a normal diet. RN Grant advised me that from her review of the food/fluid intake charts, the diet provided did not appear to be diabetic in nature.

109. Food/fluid intake charts were completed for the first three days of admission, then ceased, then recommenced five days later when Mr B was not eating well. There is no evidence that Mr B's blood sugar levels were monitored at any time during his admission. RN Grant advised:

> "It is my opinion that Food and Fluid Charts were maintained except for the omission on the dates noted. What did not appear was a systematic evaluation of reasons that [Mr B] was not eating nor that family were contacted and the issue discussed.
>
> It is also my opinion that monitoring of this man's diabetes should have been instituted to be consistent with the usual practice done at home. In addition, when his food and fluid intake deteriorated, closer monitoring of blood glucose levels should have been introduced.
>
> I am of the opinion that the departure from standards would be viewed as a moderate departure from acceptable standards by my peers."

110. The clinical nursing review dated 12 October 2015 states: "[Mr B] has certainly lost weight. He was 72kg in August last year and is now around 58kg." I consider it more likely than not that the documentation in the rest home's clinical record of Mr B's weight being 59kg on 22 December 2015 is accurate. I acknowledge that Mr B did lose weight throughout his

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admission, as this was documented as being 57.4kg on 1 January 2016 (three days prior to his discharge). While family reported that Mr B was 53kg in the week after his discharge, I cannot determine the exact amount of weight Mr B lost.

111. I agree with RN Grant that Mr B's diabetes should have been monitored, and I am highly critical that this did not occur. I also accept RN Grant's advice that a systematic evaluation of the reasons for Mr B not eating should have been undertaken, and the family consulted, and I am critical that this did not occur.

Personal care and hygiene

112. Mr B's daily cares, including showering and oral hygiene, were documented on the daily personal care charts. There are two versions of these charts, which give different information about the number of times Mr B was showered and had his oral cares completed. RN E said that staff were unable to complete oral cares owing to Mr B's aggression. On the day following Mr B's discharge, he was diagnosed with oral thrush.

113. Having considered the evidence, I find that the cares as documented in the daily personal care charts (combined) are a true reflection of the care that was provided to Mr B.

114. RN Grant advised that the lack of oral hygiene and oral assessment amounted to a poor standard of care, and that it would be viewed as a moderate departure from acceptable standards. She stated in relation to the daily personal care charts: "Documentation is poor and if it is a true reflection of what was done for this man, I must assume there was a lack of personal cares." RN Grant considered that the lack of consistent and accurate completion of the charts was a moderate departure from acceptable standards.

115. I accept RN Grant's advice and am concerned that the personal care provided to Mr B, particularly regarding oral care and showering, was lacking.

Bowel management

116. Mr B's bowel movements were not recorded regularly on the daily personal care charts, and on occasion the clinical notes are conflicting. RN Grant advised that in her opinion the documentation of care of Mr B's bowels lacked consistency, and that this would be considered a mild departure from acceptable standards. I accept this advice.

Clarification of legal status

117. Mrs B was Mr B's attorney under his EPA for personal care and welfare. However, this had not been activated by way of a medical certificate. In the rest home's clinical notes, it was documented that Mrs B was Mr B's attorney. It is apparent that staff at the rest home believed that the EPA had been activated, but there is nothing in the records from the rest home to indicate that this was the case. I am concerned that the rest home did not sight the certification required to activate the EPA for personal care and welfare, or otherwise ensure that it had been activated.

118. The rest home had a responsibility to verify Mr B's legal status and be clear about the legal basis on which it was to provide services. Whilst that is important for all health and disability service providers, the fact that the rest home regularly provides care to psychogeriatric residents means that it should be particularly vigilant in considering EPAs. I

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find it very concerning that a facility of this nature should clearly fail to be aware of the legal process in relation to consent for the care of residents such as Mr B.

Client-initiated resuscitation order

119. Mrs B was asked by the rest home to sign a client-initiated resuscitation order on Mr B's behalf. "Do not resuscitate" (DNR) orders, or advance directives, can be made by a person only when he or she is competent. A DNR order therefore cannot be made on a person's behalf, or by a person's attorney (even if the EPA has been activated). I am critical that this occurred at the rest home, where, presumably, advance directives or DNR orders are made regularly.

Conclusion

120. In my view, Radius had the ultimate responsibility to ensure that Mr B received care that was of an appropriate standard and complied with the Code. Mr B was a consumer with multiple comorbidities and challenging behaviours and he was temporarily moving into a respite care facility where he would be unfamiliar with staff and his surroundings. In my view, these circumstances made Mr B particularly vulnerable. I am critical of the rest home that there was not a clear assessment at the outset of the clinical and behavioural issues that could arise during Mr B's respite stay, and that there was a lack of evaluation of the whole clinical picture of Mr B's declining health. In addition, I consider that the following deficiencies are apparent in the care Mr B received from Radius:

- Restraint policy and procedure were not followed;
- Mr B's medication regimen was not reviewed in light of his deteriorating condition or prescription;
- Mr B's diabetes was not monitored;
- An evaluation of the reasons for Mr B not eating was not undertaken;
- Personal cares for Mr B were lacking;
- Mr B's legal status was not clarified; and
- Mrs B was asked to sign a DNR order on Mr B's behalf.

121. Overall, I do not consider that the care provided to Mr B by Radius was adequate. Accordingly, I find that Radius Residential Care Ltd did not provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: RN E — breach

Restraint

122. RN E was the Restraint Coordinator at the rest home. The Radius Clinical Manual — Restraint Policy and Procedure states that the Restraint Coordinator is responsible for ensuring compliance with this restraint policy, as well as with NZS 8134.2.2008. Mr B was restrained with a lap belt on ten occasions over nine days by various rest home staff. The restraint documentation was not filled in adequately by rest home staff. The consent form

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regarding restraint was signed only by RN E, and a medical officer was not consulted about the use of restraint.

123. My expert advisor, RN Jan Grant, advised:

> "I am of the opinion that [RN E] failed to carry out the requirement of the [Health and Disability Service Standard][11] in relation to all areas of the requirements from assessment, consent, documentation, monitoring and documentation, and incident reporting."

124. RN Grant further advised that RN E's failure to follow correct procedures in relation to restraint use would be viewed by her peers as a severe departure from acceptable standards.

125. I acknowledge RN E's explanation that he did not receive proper induction to the Restraint Coordinator role, or senior oversight, and that he was not given time over and above his registered nursing duties to ensure that restraint use complied with relevant policies and standards. I note that Radius advised that RN E did receive induction to the role on 20 January 2015. I also acknowledge that it was common practice for HCAs to manage and sign off restraint cares, and that RN E stated that he was not told that this was not correct according to the restraint policy.

126. Despite the pressures described by RN E, I consider that he should have at least familiarised himself with the restraint policy and procedure. I accept RN Grant's advice and am concerned that, as the Restraint Coordinator, RN E repeatedly allowed Mr B to be restrained by a lap belt despite consent not having been obtained, documentation not having been completed appropriately, and a medical officer not having been consulted — all of which were required by the rest home policy.

Alleged manual evacuation

127. On 1 January 2016, RN E attended when an HCA found that Mr B was constipated. It was documented in the progress notes that Mr B was constipated and was "helped to moved bowels manually" by two HCAs and a registered nurse (RN E). The progress notes state that Mr B's bowels had opened the previous day.

128. RN E states, however, that a manual evacuation did not occur, and that the HCA massaged the anal area to enable a bowel movement, which occurred. RN E said that, on reflection, he should not have approved of the HCA's action because this would be considered an invasive action without consent.

129. RN C also told HDC that the anal area was "only massaged". However, Ms A recalls that following a discussion with RN E, RN C demonstrated to her that there had been an insertion of two fingers.

[11] NZS 8134.2.2008 Health and Disability Service Standard (restraint and minimisation and safe practice standards).

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130. RN Grant advised:

> "It is my opinion that if the Deputy Commissioner finds that there was a manual bowel evacuation (digital insertion) that occurred on the 1st January, then the departure from an acceptable standard would be considered a severe departure. As previously noted in my advice the documentation lacked consistency and there are conflicting and different accounts of this event. His clinical notes, however, indicated that he had a bowel motion on the 31.12.15 and so there is no clinical indication to suggest a manual bowel evacuation the following day was justified. No invasive procedure should have been done by care staff at any time."

131. Unfortunately, I am unable to make a finding as to whether or not there was a digital insertion, given the different accounts of events. However, given that Mr B had had a bowel motion the previous day, I consider that there was no urgency to perform either an anal massage or a manual evacuation, and I am concerned that as the responsible registered nurse, RN E allowed this to occur. I am also concerned that consent was not obtained from Mr B, or if he was not competent to consent and in the absence of any person being entitled to consent on his behalf, that his family was not consulted prior to the procedure.

Conclusion

132. RN E had a responsibility to ensure that Mr B received care that complied with the Code. I am critical that in his role as Restraint Coordinator, RN E allowed restraint to be applied to Mr B in a manner that did not comply with Radius policy. Further, I am concerned that RN E allowed an invasive procedure to be performed by an HCA without clinical indication. I do not consider that RN E provided services to Mr B with reasonable care and skill. Accordingly, I find that RN E breached Right 4(1) of the Code.

133. Right 7(1) of the Code states that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. For the reasons outlined above, I am not satisfied that Mr B gave informed consent to the use of restraint or the anal massage/manual evacuation, or if he was not competent to consent and in the absence of anyone being available to consent on his behalf, that his family were not consulted. Accordingly, I find that RN E breached Right 7(1) of the Code.

Opinion: RN C — breach

Admission

134. At the time of these events, RN C was the Facility Manager at the rest home and it was her responsibility to complete and prepare documentation relating to pre-admission enquiries. She sent a brief email to Mr B's daughter advising what he needed to bring, but did not provide the family with a pre-admission form or request further information. There is no evidence from the clinical records or responses provided to HDC that the psychogeriatric unit staff were orientated to the particular challenges Mr B might present during his respite period.

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135. My expert advisor, RN Jan Grant, advised that Mr B's situation should have raised a number of red flags from the time contact was first made about his respite admission. She stated:

> "He was a gentleman with multiple medical problems and increasing dementia with episodes of aggression at times. His previous respite admission had indicated that there were difficulties with his settling into a new environment. He had been seen by a psychogeriatrician and there had been adjustments made to his psychotropic medication. Weight loss had been observed. He was being admitted for respite care over the Xmas/New Year period when staff members were away on leave and some shifts were likely to be covered by agency staff. It is my opinion that as much accurate information should have been available by the time [Mr B] was admitted and that the nursing staff on the Dementia Unit should have been briefed as to the clinical issues which might arise during his stay."

136. I accept RN Grant's advice, and am concerned that given Mr B's particular challenges, information about managing his behaviours was not sought from his family, and staff were not briefed on the clinical issues that could arise during his stay. In my view, this was particularly important given that RN C was going to be away for much of Mr B's stay, and because Mr B's multiple comorbidities and challenging behaviours made him particularly vulnerable, especially in a respite care setting where he would be unfamiliar with staff and his surroundings.

Staffing

137. It was RN C's role to manage staff and resources to ensure the delivery of safe, effective, and quality health care. RN C was away for eight days of Mr B's 14-day admission. Radius stated that RN C was not on approved annual leave, and it was her responsibility to ensure that a senior clinician was available for after-hours cover. CNM D was also away for nine days of Mr B's admission, and some registered nurse shifts were covered by bureau staff. RN Grant advised:

> "I am of the opinion that senior management did not provide adequate staff that allowed for professional clinical oversight for both Registered Nurses and Caregivers over the [Christmas] holiday period …
>
> I am of the opinion that overall staff and clinical support is the responsibility of the Facility Manager. Throughout her statement she acknowledges the lack of care but indicates that policies and procedures were not followed. All of which she had no knowledge of. Ultimately some responsibility for the poor care must be attributed to staffing, skill mix and education, all of which played a part in care delivery."

138. I accept RN Grant's advice. Although I acknowledge that RN C was off site for much of Mr B's admission and was not made aware of Mr B's condition, I still consider that RN C was responsible for ensuring that there was a suitable arrangement of senior staffing over the holiday period to provide oversight to registered nurses and healthcare assistants, and I am critical that this was not in place. In making this criticism, I acknowledge RN C's view that there was senior coverage confirmed and a good balance of skill mix cover. However I also note that she was aware that employees would ring in sick, almost on a daily basis.

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Conclusion

139. As Facility Manager, RN C had a responsibility to provide an appropriate standard of care to Mr B, even though she was not physically on site for much of his stay. In my view, the admission process undertaken by RN C for Mr B was suboptimal, and there was not adequate senior staffing oversight during the respite period. Accordingly, I find that RN C did not provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: CNM D — other comment

140. CNM D was responsible for managing staff and resources to ensure that safe and effective professional quality care services were provided to all residents within the facility. CNM D was off site from the rest home for nine days of Mr B's admission, and said that when she was on site during that time, she was usually working in the hospital wing. CNM D raised concerns about her workload and not being able to complete her job as per her job description.

141. CNM D stated that no concerns were reported to her by the registered nurse team or the family of Mr B during his entire stay.

142. My expert advisor, RN Jan Grant, acknowledged that it was the CNM role to oversee and provide support to clinical staff. However, she advised:

> "In relation to the responsibility and work load for [CNM D], she made several statements about the pressure of work, the overtime required and the need for her to 'fill in on the floor' when staff were sick or did not turn up at work. She also was available to be contacted 24/7 and was expected to attend the facility when she was off duty and on annual leave to address issues …
>
> In attempting to fill in and cover and making herself available, she was not able to complete her role as clinical manager. This lack of clinical supervision I believe contributed to the poor care.
>
> It is my opinion that this work load was unsustainable. Obviously providing support for staff and family was important but in so doing, I believe [CNM D] was unable to fulfil her role as Clinical Manager. Having identified her concerns to management no action appears to have been taken to address these concerns."

143. I accept RN Grant's advice. In these circumstances, I am not critical of the care provided to Mr B by CNM D.

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Recommendations

144. In the provisional opinion, I recommended that Radius Residential Care Ltd:

a) Provide further training for all rest home staff on the NZS 8134.2.2008 Health and Disability Service Standard (restraint and minimisation and safe practice standards). Radius confirmed that this training has been completed and is now scheduled to occur on a three-monthly basis.

b) Undertake an audit of the restraint use consent forms that have been completed in the past six months, to see whether they have been completed in line with Radius policy. Radius advised that this recommendation was completed, and provided the most recent restraint audit results.

c) Undertake a review of its processes in relation to respite assessment and care planning, documentation, medication management, and management of complex conditions (eg, diabetes). Radius advised that this process was carried out and no deficiencies were identified.

d) Undertake a review of the staffing levels and skill base at the rest home, particularly in the psychogeriatric unit and in relation to the Facility Manager and Clinical Nursing Manager roles, and report back to HDC with details of any changes to the staffing structure. Radius stated that the Team Leader role was created following this complaint; all staff have completed or commenced dementia training; and the current Facility Manager and Clinical Nursing Manager have extensive experience with dementia clients and challenging behaviours.

e) Update the client-initiated resuscitation form to make it clear that this can be signed by a client only when the client is competent. Radius advised that the form has been updated.

f) Update the resident register documentation to include a prompt to staff to query and document whether or not a resident's EPA has been activated. Radius stated that it agrees with this recommendation and it will be complied with.

g) Provide an update to HDC advising of the work that has been undertaken with the DHB to ensure that service provision requirements have been met. Radius referred to the changes made (eg, staffing) and stated that it will continue to work closely with the DHB.

h) Provide a written apology to Mr B's family for the failures identified in this report. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding to Mr B's family. Radius agreed to comply with this recommendation.

145. I recommend that RN E:

a) Undertake training on informed consent, and report back to HDC within three months of the date of this report to confirm that he has done this, and with a statement of personal reflection.

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b) Undertake training on the NZS 8134.2.2008 Health and Disability Service Standard (restraint and minimisation and safe practice standards), and report back to HDC within three months of the date of this report to confirm that he has done this, and with a statement of personal reflection.

c) Provide a written apology to Mr B's family for the failures identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Mr B's family.

146. I recommend that RN C provide a written apology to Mr B's family for the failures identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Mr B's family.

Follow-up actions

147. Radius Residential Care Ltd 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.

148. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Radius Residential Care Ltd, will be sent to the Nursing Council of New Zealand, and it will be advised in covering correspondence of the names of RN C, RN CNM D, and RN E.

149. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Radius Residential Care Ltd, will be sent to the District Health Board.

150. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Radius Residential Care Ltd, will be sent to HealthCERT, the New Zealand Nurses Organisation, and the Health Quality & Safety Commission, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

151. The Director of Proceedings decided to issue HRRT proceedings, which are pending.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Registered Nurse Jan Grant:

"I have been asked to give an opinion on the respite care provided to [Mr B] by the staff at [the rest home].

I have no personal or professional conflict of interest in the case. My advice is based on a review of the documentation provided.

I have read and agreed to the Commissioner's guidelines.

I am a Registered Nurse with 30 years' experience in Aged and Community Care. I have had a variety of roles. I have represented NZNO and the Aged Care sector on a number of national working parties. I was involved in setting standards of practice for Gerontology Standards. I have been a Director of Nursing, Manager, clinical tutor and guest speaker both here in New Zealand and overseas. I have had international papers published. My present role is as Clinical Advisor/ Rehabilitation Coordinator in the community. I am a designated assessor for ACC.

I have been asked to comment on the following:

1. What is the standard of care and accepted practice?
2. If there has been a departure from the standard of care or accepted practices, how significant a departure do you consider it to be?
3. How would it be viewed by your peers?

<u>Background Information</u>

[Mr B] was admitted for respite care on the 21.12.15 for 2 weeks. Before admission for his respite care, he lived with his wife, [Mrs B], in the family home. [Mrs B] was the major carer and was supported in this by care workers who visited the family home.

Documentation from a Clinical Nursing Review letter, in the clinical records, outlined his medical history, medications, recent investigations, social history, functional abilities and a summary of his condition and the reasons for the respite. The letter was written in October, 2015 and mentions some infrequent episodes of aggression at home and further aggression during a previous period of respite care.

In November, 2015, [Mr B] was reviewed by [a psychiatrist] — and a letter written by him to [Dr F], GP, states that [Mr B] would need a secure psychogeriatric setting with appropriate staff/patient ratio. [The psychiatrist's] letter lists the medications being used at this time, and an increase in psychotropic drugs is noted.

The letter written to the facility [the rest home] outlined medical conditions and showed a high level of support and care was needed.

<u>Restraint Care</u>

Restraint cares is covered under the Standard NZS8134.2:2008

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NZS 8134.2:2008:

Health and Disability Services Standards — Health and Disability Services (restraint minimisation and safe practice) Standards

This Standard is to be read in conjunction with NZS 8134.0:2008 Health and Disability Services (general) Standard which contains the definitions and audit framework information applicable across the Health and Disability Suite. NZS 8134.2:2008 is the result of the first revision of NZS 8141:2001 Restraint minimization and safe practice. It aims to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It provides guidance on restraint minimisation, safe restraint practice, and seclusion. All services must meet NZS 8134.2.1. NZS 8134.2.2 and NZS 8134.2.3 will be assessed as being not applicable to a service where restraint and seclusion are not used.

[Mr B] was admitted on the 21.12.15 and on the pm shift on the day of admission, his notes state that:

'*[Mr B] has been walking around getting into things moving etc … couldn't do cares as he wouldn't come with me'*

Notes from 21.12.15 at 2330 state '*[Mr B] was confused agitated and combative at 1900PM PRN risperidone given with good effect … an A+I completed for a skin tear on his L upper wrist. Wound alignment done'*

22.12.15 notes of pm shift state:

'Restless since the beginning of the duty not distractible wandered around pushing (lifting chair in deck climbing over chair) table increased physical aggression when I tried to direct the client PRN Risperidone given around 2000 with medication settled to be at 2030…'

On the 23.12.15 clinical notes indicate that [Mr B] was unsettled and was kneeling on the floor.

At 1600 the Registered Nurse states:

'Informed wife re: A&I happened yesterday. [Mrs B] (wife) agreed to use PRN lap belt for client's safety. And she may come in on Boxing Day to sign the consent. Rang [the medical centre], re chart meds on our drug chart …'

Policies and Procedure

The documentation provided by Radius Care outline their Restraint Minimisation and Safe Practice Policies and Procedures.

I reviewed Radius Policies and Procedures for Restraint.

The policies were reviewed on December 2012. They consist of 10 pages incorporating Purpose/Policy, Scope, Associated Documents, Definitions, Work Instructions, Methods, Use of Enablers, Enablers permitted with Aged Care, Clients' Rights,

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Assessment, Discussion and Restraint Alternatives, Restraint Alternatives not effective, Restraint Episode Evaluation, Risks associated with Restraint, References.

The Policies and Procedures clearly outline the required steps, the forms used in the event of restraint being used and the rationale. In my opinion they would meet the standards NZS8134: 2008. I did not view all of the required forms that would be included with this standard as they were not presented in the documentation provided to me.

Documentation used in relation to the use of restraint of [Mr B]:

The Consent Form was included. This form indicated it consists of three pages, but only two pages were included in the documentation presented. The first page outlined the outcomes, the restraint method to be used, the risks associated with this and a section that related to the discussion with family/whānau. It stated to document outcome. The entry that is written is '*Family + RN on duty'*.

The final question on this page is:

Is everybody in agreement that a restraint trial period is to commence? 'Yes' is circled.

The last page of the form listed what type of Restraint would be used and 'Lap Belt' is written and the word 'Agreed' is circled.

With respect to the maximum time frames that restraints can be used and monitoring time frames, 'Agreed' is circled and '30 min' is written.

[Mr B's wife] signed on the **25.12.16** and the Registered Nurse signed on the **26.12.16.**

Five Restraint Monitoring Forms were supplied with the documentation reviewed.

The first note of restraint being used was on the **24.12.15** which indicated the LB (Lap Belt) on at 2100hrs and LB on at 2200hrs, 2300 LB on/off 24.00 LB off SLP bed. The last 2 entries are signed with an CNM Designation. The type of restraint used was listed.

The second page of the Restraint Monitoring Form is for the **25.12.15**:

Restraint on at 1100hrs, off/on at 1200, on at 1300hrs, 1400 hrs off/on, 1500hrs on. A signature is noted but not legible. The designation of the person signing this form is not listed. Lap belt as the type of restraint used is listed in the column at the top of the page.

The third page of the Restraint Form is dated the **27.12.15**. It states as follows: Restraint on at 1300, on at 1400 and off at 1500. It lists lap belt as the type of restraint used. The entries are signed but no designation is listed.

The fourth page of Restraint Form is dated **29.12.16**: 0600 lap belt on, 0700 lap belt on, signed by HCA, 1500 LB on, 1700 LB off MLT, RP, 1800 LB on SUP, 1900 LB off MLT, 2100 on, **pt unsteady on feet**, 2200 LB on/off SUP. Entries are signed by the HCA (Health Care Assistant).

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Progress Notes showed that restraint was used on the 23.12.16:

'informed wife re A&I happened yesterday. [Mrs B] (wife) agreed to use PRN lap belt for client's safety. And she may come in on boxing day to sign consent …'

24.12.15 *'… unsteady on his feet and PRN lap belt used for his safety'*

24.12.15 2230hrs *'very very agitated and unsteady on his feet. Restrained him. Tried to stand up with restraint and he fell on the floor with chair…' '… PRN risperidone given as charted still tried to walk and unsteady. Restrained and settled …'*

The drug chart indicated Risperidone given at 2100hrs.

25.12.15 1500 *'… Applied restraint for his safety. Regular checks done.'*

26.12.15 '… became agitated and had to be restrained 1100 visited by family'

29.12.15 '… L/B used today for his safety'

29.12.15 '… he was restrained on a chair in the afternoon'

30.12.15 'up in the lounge but restrained on a chair'

31.12.15 '… Restrained on a chair'

1.1.16 '… [Mr B] has been restraint all afternoon as he was trying to get up but not walking properly…'

2.1.16 1415 '… up in the lounge lap belt on @ 0945am'

I did not view all of the required forms that would usually be included with this standard as they were not presented in the documentation. I have assumed that these forms were not completed.

Summary of Restraint Care

Although adequate documentation in relation to Policies and Procedure is available, it is my opinion that they were not followed and not fully implemented.

Starting with the Consent Process, information in the Progress Notes indicated that the RN rang [Mrs B] and gained consent over the phone, there is a Consent Form signed by [Mrs B] on the 25.12.15 but it is scantly filled in and in my opinion does not include adequate information or the rationale required to meet this policy and the standards.

Policy stated that the RN will clinically assess the Client, and consult with at least one other member of the multidisciplinary team. [Mr B's] doctor would in my opinion be the obvious choice. The entry in the Progress Notes stated that the nurse spoke to the client's wife re restraint and on the same day, phoned the GP re medications. It was not documented that the GP was included in the restraint discussion.

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Policy was not followed in relation to discussion, or if it was, this was not documented. The policy stated that restraint is used as the last resort, not a first treatment option. There is scant/nil information in the Progress Notes to show what, if any other alternatives were used. One would expect a patient such as [Mr B], who was an active, outdoor gentleman to be offered walks and other de-escalation interventions. There is no evidence of this in the notes.

Risk factors were documented and notes indicated that [Mr B] did fall from the chair on the 24.12.16 while he was restrained.

The Restraint Monitoring Form was very poorly completed and this is evidenced by the Clinical Notes which showed the four days when restraint was used, no documentation was completed.

The Nursing Review letter stated that [Mr B] had been [a great walker] but that he was now not leaving his home on his own. His mobility had clearly deteriorated. He had a super stroller that he was using both inside and out. It stated that he did not show signs of increasing stiffness or shuffling in gait, and that he appeared to maintain a reasonable heel to toe lift.

There is no documentation in relation to assistance with walking or strategies to walk with or assist with mobility.

Summary

It is my opinion that Restraint Cares were poorly managed, very poorly documented and did not meet the standards in relation to NZS 8134.2.2008 Health and Disability Service Standard (restraint and minimisation and safe practice standards).

I believe my peers would view this as a severe departure from acceptable standards.

<u>Bowel care</u>

A Daily Personal Care Chart is used to record personal cares, and bowel cares are listed on this. This chart is not completed and there are days where no entries in relation to bowels were listed.

The Clinical Notes are at times conflicting in nature as the entry on the 23.12.15 stated:

'*Bowels not opened. Continent of both urine and faeces on this shift'*

The Progress Notes indicated that [Mr B] was constipated and was assisted to move his bowels by two HCA and RN. Documentation by the Registered Nurse on the 8.3.16 stated that the HCA did not do a manual evacuation, but massaged the anal area to enable a bowel movement.

Summary

It is my opinion that the monitoring/documentation and care of [Mr B's] bowels lacked consistency.

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I am of the opinion that this would be viewed as a mild departure from acceptable standards by my peers.

Hydration/Nutrition

Admission information faxed from the Gerontology Nurse Specialist clearly documented [Mr B's] medical history which included Type 2 Diabetes. This was supported by a list of his medications, which included both Metformin and Gliclazide, both used for diabetics. On the Weight Record Sheet, weight is listed as 59 kg.

The Clinical Review letter from the Registered Nurse, dated Oct., 2015, stated that [Mr B] had lost weight and that his weight in August was 72kg but he was now (12.10.15) 58kg.

The first entry in to the Progress Notes stated that [Mr B] has a '*diabetic diet — normal, kitchen updated'*.

The Respite/Short Term Care Plan listed on the medical history as *'DM type II'* but under eating and drinking it lists meals as *normal diet*.

The Dietary Requirement Form listed the diet as '*Diabetic'*.

There are nine Food and Fluid Intake Charts and dates include

22.12.15

23.12.15

24.12.15

30.12.15

31.12.15

1.1.16

2.1.16

3.2.15 (I have assumed this is 3.1.16)

Dates which no record of food or fluid intake include 25, 26, 27, 28, 29th December. The first chart dated on 22.12.15, [Mr B] appears to have eaten well, but other charts showed that he refused meals or ate very little, the last two intake charts showed that he declined or refused most food.

Radius Care has adequate policies and procedure in relation to Nutrition and Hydration.

Summary

From the documentation I have reviewed, it appears that on the first day at the facility, [Mr B] ate well but that his intake declined from then on. The management of oral food and fluid intake was documented on the dates as stated. There appears to be no interpretation/investigation as to the reason why he declined food and fluids. Family

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have stated that [Mr B] left Radius Care with oral thrush and this may well have contributed to his refusing food and fluids.

There is no information in the notes to show that either care support staff or registered nurses, assessed [Mr B] for thrush and assisted with oral hygiene cares which may have alerted staff that there were other issues in relation to his refusing meals. It does appear that the facility did not notify anyone, such as his doctor, when his food and fluid intake decreased. Also family do not appear to have been informed of this.

It is unclear from the notes whether a diabetic diet was followed. The Short Term Care Plan does not list a diabetic diet, but listed a normal diet. The Dietary Requirement Form has a tick to show that a diabetic diet was indicated and ordered, and the Progress Notes on admission stated diabetic diet. The Food and Fluid Intake Chart, I believe indicated that a diabetic diet was not followed as much of the food listed does not appear to be diabetic in nature.

There is nothing in the Clinical File as to the frequency of blood sugar monitoring. It would be expected that staff would request this information from health professionals and/or family when a client is admitted with Type 2 Diabetes. It is usual for families of respite patients to bring the Blood Sugar Level book into the Facility so that recordings may be continuous. This also gives staff background information that acts as a good baseline for ongoing diabetic management. The Facility would be expected to continue the regime the client had at home, and certainly it would be common practice to record and monitor blood sugar levels in the event of a diabetic client not eating or drinking. Registered Nurses can and should initiate this without medical approval. Family could have given information verbally as to the frequency of blood glucose levels being taken at home and what was a normal range for [Mr B].

Summary

The lack of oral hygiene and oral assessment I believe amounted to poor standard of care and would be viewed with moderate departure of acceptable standards from my peers.

It is my opinion that Food and Fluid Charts were maintained except for the omission on the dates noted. What did not appear was a systematic evaluation of reasons that [Mr B] was not eating nor that family were contacted and the issue discussed.

It is also my opinion that monitoring of this man's diabetes should have been instituted to be consistent with the usual practice done at home. In addition, when his food and fluid intake deteriorated, closer monitoring of blood glucose levels should have been introduced.

I am of the opinion that the departure from standards would be viewed as a moderate departure from acceptable standards by my peers.

<u>Medications</u>

Medical and Clinical Nursing Review Notes included a letter and this was faxed to the facility listing medications. The letter from the psychiatrist to [Dr F], dated Nov., 2015,

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listed Risperidone 0.5mg at noon and 1mg at night plus 1.5 mg PRN. Quetiapine 25 mg prn for agitation.

The Clinical Nursing Review, dated Oct., 2015, listed medications as Risperidone 0.5mg OD.

The Medication Order Sheet which was faxed by the GP, and signed on the 23.12.15, listed Risperidone 0.5 BD and Quetiapine 25 mg TDS. It also listed Risperidone 0.5mg PRN 8hrly for what appears to be agitation (difficult to read).

The patient's medical history also supported this. On 2.12.2015 Quetiapine 25mg 1 tabs tds and risperidone 0.5mg 1 tabs bd and PRN for agitation and restlessness.

The medication listed on the blister packs has Quetiapine fumarate as follows: take one tablet three times a day. It appears that the lunch and breakfast line was added and is not a typed note. Risperidone 0.5mg, take one tablet twice a day, lunch and breakfast is also listed.

Non packaged medications listed Risperidone as being given on the:

22.12. at 1930 hrs

23.12 at 1100hrs

24.12. at 2100hrs

refused on the 25.12.15

2.1.16 at 2350hrs

Non-packaged regular administration record lists Quetiapine as being given at 8am and 12 md daily from admission.

Summary
Medication administration for [Mr B's] stay at [the rest home] appears to be different from what was administered at home. Family have stated that he only received Quetiapine daily when at home and the medical chart indicates that he was having this three times a day.

I cannot say who wrote in the extra two marks on the blister packs but I believe it should have been questioned on admission by nursing staff with the doctor and the pharmacist. This was not done till the 23.12.15 when the doctor faxed the medication chart back which states that Quetiapine is given three times a day.

There is some inconsistency between the Progress Notes and the Drug Chart.

On the 2.1.16 the am. notes stated '*regular meds given as charted W/H his 0800 risperidone because was sleepy and unsteady on feet'* this does not show on the drug chart.

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On the pm shift both risperidone and quetiapine were withheld yet only quetiapine was shown on the drug chart.

It appears that [Mr B's] medication management contributed to his becoming frail and unable to mobilize.

The notes also indicate that he was dehydrated and refused to eat and drink.

It appeared that administration of medications was done in isolation and not the 'whole picture' reviewed. There was not a medical review in the time that he was at the facility. My view is that had this happened the Doctor may well have identified the high doses of psychotropic drugs that he was getting, in view of his increasing frailty and dehydration, and may well have made changes to the medication regime.

There does not appear to have been any family contact in relation to medication dosages.

In addition there was no communication with family to try and determine the patient's inability to mobilise which became worse over the course of this admission.

I believe my peers would view this as a moderate departure from acceptable standards.

General Nursing Cares

Activities of daily living/general cares are documented in the Daily Personal Cares Chart and supported by the Clinical Progress Notes. Two Daily Personal Care Charts were presented with the documentation for the 1st–4th.

Showering: the documentation showed that [Mr B] was showered on the 24th, 25th, 29th, and the second set of Personal Care Charts are inconsistent. One stated that [Mr B] showered on the 1st, 2nd and 3rd while the other stated that he was only showered on the 4th.

Oral Hygiene: His dentures and teeth were cleaned on the 22nd, 23rd, 24th, 25th, and the 28th of Dec and the 1st of Jan 16. Oral hygiene was only completed once a day.

Personal Care Chart: The use of the Daily Personal Care Chart in my opinion lacks consistency. Documentation is poor and if it is a true reflection of what was done for [Mr B], then I must assume there was a lack of personal cares for this man.

Temperature: Documentation showed that [Mr B] had what staff has described as sleep apnoea and baseline recordings were taken. The temperature was recorded as 38.8. There is no analysis of this listed and no follow up regular monitoring was put in place. His temperature does not appear to have been taken as notes in the Progress Notes on the PM shift of the 3.1.16 '*obs taken and recorded in the book*' but there is no recording of the observations in the documentation reviewed.

Summary

The forms that the facility had were not completed consistently and accurately.

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I am of the opinion that this would be viewed as a moderate departure from acceptable standard by my peers.

Overall summary of care:
[Mr B's] care, I believe from the documentation presented, demonstrated a number of issues:

- Restraint policies and procedure not followed.
- Food and fluid not recorded accurately and consistently.
- Daily cares not recorded accurately and consistently.
- No consistent/systematic review of deterioration in his general condition including weight loss.
- Limited family communication in relation to patient's declining health.
- Poor management of bowels/constipation.
- Poor management of his Type 2 diabetes.
- Policies and procedures not followed.
- No review of medication when patient's condition changed.
- No systematic review of abnormal recordings

I believe that the notes I have reviewed show that each issue in relation to [Mr B's] stay was treated in isolation to other events, whether it was each shift, or daily, over the time he was at [the rest home]. I believe the notes show that there was no adequate follow up, and no systematic gathering of information for an evaluation of the whole clinical picture of his declining health. They also show a lack of good clinical reasoning by registered staff. It would be expected in practice to evaluate declining health in any client under their care, especially short term clients who decline so quickly.

It is acknowledged that [Mr B] presented challenging behaviours but there was no evidence of medical input or advice sought from appropriate health professionals.

I believe that the standard of care would be viewed as a moderate to severe departure from acceptable standards by my peers."

The following further advice was received from RN Grant:

"I have been asked to review the following information provided:

1. My preliminary advice dated 26 June 2016
2. Letter of complaint [date] and subsequent information provided by complainant including email dated 7 March 2016
3. Relevant GP records
4. [DHB] investigation dated 14 April 2016 and response from family
5. Radius's response dated 18 May 2016 and attachments
6. [DHB] complaint follow-up dated 14 September 2016 and site visit report dated 25 September 2016
7. [RN C's] response to notification dated 20 February 2017 and attachments
8. [RN E's] response to notification dated 21 February 2017
9. Radius's response to notification dated 24 February and attachments

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10. [CNM D's] response to notification dated 28 February 2017

I have been asked to review the enclosed documentation and advise whether the care provided to [Mr B] by Radius and its staff was reasonable in the circumstances and why.

RADIUS:

Whether the additional information provided causes you to change your advice in any way. If so why?

Having read the supporting information I have not changed my views and support the opinion that I provided on the 26 June 2016. A summary of my findings from my initial advice are:

- Restraint policies and procedure not followed.
- Food and fluid intake not recorded accurately and consistently.
- Daily cares not recorded accurately and consistently.
- No consistent/systematic review of deterioration condition including weight loss.
- Limited family communication in relation to patient's declining health.
- Poor management of bowel function/constipation.
- Policies and procedures not followed.
- No review of medication when patient's condition changed.
- No systematic review of abnormal recordings

1. The adequacy of relevant policies and procedure in place at Radius

The policies and procedures in place appear to be adequate to meet the requirements of certification. The policies that were supplied include:

- Pre-Entry and Admission
- Assessment Care Planning and Review
- Nutrition and Hydration
- Restraint/Challenging Behaviour
- Clinical Records
- Safe Administration of Medication/Medication Reconciliation
- Grooming/Hygiene Care

It is noted that many of the policies were reviewed in 2012 and were due for clinical review in 2016.

2. The adequacy of the training provided to staff.

I have reviewed the extra training provided to the staff and it appears to be consistent with current practice. I was not provided with details of the education attended by the care staff providing care to [Mr B].

3. The adequacy of staffing over the Christmas holiday period. Any other matters in this case that you consider warrant comment.

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I have read both [CNM D's] and [RN E's] statements. Both RNs indicate that staffing shortages and lack of trained staff were an issue. [CNM D] states that over the holiday period no extra staff was allocated to replace her. She states that she was on call duty when away over the statutory holidays and weekends. Often she was called 3–4 times per night and at weekends, when she would attend on site to sort out issues. She states that she worked between 12–15 hours per day and worked double shifts, as well as filling in on the hospital ward, to ensure coverage.

She also states that staff was told by management not to use agency staff due to budget constraints.

It is noted that all senior management were away on annual leave over the Xmas period. [RN C] (Facility Manager) stated she was away for 8 of the days of [Mr B's] stay. She states that *'[the] (CNM) and [the] (Regional Manager) were left to cover and be on call should there be any concerns.'*

[CNM D] (Clinical Nurse Manager) was also away for 8 days of [Mr B's] stay. She stated she was called several times a night and was required to attend to address issues. It appears that [CNM D] was in fact on call and not on annual leave.

I am of the opinion that senior management did not provide adequate staff that allowed for professional clinical oversight for both Registered Nurses and Caregivers over the Xmas holiday period.

[RN E] states that there were staff shortages and that it was very hectic working in a psychogeriatric ward with 19 patients, inexperienced staff and a lack of skill mix.

I have reviewed the roster provided by [the rest home] for the Dementia Unit. Over the holiday period the roster shows that four RN shifts were covered by Bureau staff. If the roster is correct and the staff did the completed shifts then adequate staffing was provided as per the hours allocated. Time sheets were not viewed and the roster does not indicate if staff attended the designated shifts. The time sheets do not show the experience of the staff employed or the required attendance of dementia training as per contractual arrangements. Time sheets also do not show if the Registered Nurses were required to work in other parts of the facility and cover other responsibilities.

I am of the opinion that senior management did not provide adequate staffing that allowed for professional clinical oversight for both Registered Nurses and Caregivers over the Xmas holiday period.

I am also of the opinion that the standard of care given to [Mr B] showed a lack of supervision of care workers. In addition, my opinion is that there was a lack of appropriate assessment and adequate follow up by registered staff. I am of the opinion that there was a failure to follow documented policies and procedures, and there was poor communication with family members.

Senior management have a responsibility to ensure that there is adequate clinical supervision, staff support and experienced skill mix for both care workers and

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registered nurses. It is my opinion that this did not occur and hence contributed to the lack of care for [Mr B].

4. Any other comments about the responsibilities and care provided by individual staff

The roster shows that other Registered Nursing staff were on duty. I do not know if they were permanent staff or holiday relief staff. It must be acknowledged that RN staff has an individual responsibility for the care and supervision they provide, but this can only be done in an environment where they are supported and not expected to take on other responsibilities. There appears to be a lack of training in relation to specific dementia care.

As previously stated I do not believe there was a systematic review and assessment of the multiple medical and behavioural issues suffered by [Mr B].

[RN C] (Facility Manager)

1. The adequacy of the care provided to [Mr B] by [RN C] as Facility Manager.

[RN C's] response, dated 20 February 2017, states that she was employed as the Facility Manager from May 2015 until March 2017. Included in her responsibilities was the admission and preparation for patients being admitted for short or long term care.

The Facility Manager's job description at the time, listed the main purpose of the job as '*To manage staff and resources to ensure the delivery of safe, effective and quality life and health services are provided to all residents within the facility.'*

Key activities are listed under the heading of Leadership and Management. These include ensuring that:

The Radius Residential Care Ltd philosophy of care is provided.

Effective communication and teamwork and an excellent standard of clinical practice is implemented.

Gerontology best practice is delivered at all times.

Other key activities include Marketing/Promotions, Occupancy Management, Risk Management, Financial Management, People Management and Quality and Health and Safety.

[Mr B's] family made contact with [RN C] in mid-December regarding preparation for his stay. She forwarded family an email outlining required clothing and toiletries for his stay. No other pre admission information was sent to family. On the day of admission [RN C] welcomed [Mr B] into the facility. Admission notes do not have any entries from the Facility Manager and from her statement it does not appear that she had contact with, or provided clinical support to staff/family once [Mr B] was admitted.

[Mr B's] situation should have raised a number of red flags from the time his wife first made contact with the facility. He was a gentleman with multiple medical problems and

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increasing dementia with episodes of aggression at times. His previous respite admission had indicated that there were difficulties with his settling into a new environment. He had been seen by a psychogeriatrician and there had been adjustments made to his psychotropic medication. Weight loss had been observed. He was being admitted for respite care over the Xmas/New Year period when staff members were away on leave and some shifts were likely to be covered by agency staff. It is my opinion that as much accurate information should have been available by the time [Mr B] was admitted and that the nursing staff on the Dementia Unit should have been briefed as to the clinical issues which might arise during his stay.

I am the opinion that overall staff and clinical support is the responsibility of the Facility Manager. Throughout her statement she acknowledges the lack of care but indicates that policies and procedures were not followed. All of which she had no knowledge of. Ultimately some responsibility for the poor care must be attributed to staffing, skill mix and education, all of which played a part in care delivery.

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

Policies and Procedures do guide staff, both registered staff and care workers. Senior management have the responsibility to ensure that policies and procedures are followed. The comments from [CNM D] and [RN E] indicate that following the complaint an extensive education programme was put in place to address the short-comings of care and service delivery. Education should be ongoing and not as a result of a complaint.

<u>RN [CNM D] (Clinical Nurse Manager)</u>

1. The adequacy of the care provided to [Mr B] by [CNM D] as Clinical Nurse Manager.

[CNM D] has provided two statements — the first statement on the 7.3.16 and the second on the 28.2.17. In her first statement she noted her responsibility was as Clinical Nurse Manager and the job description (Document No 4) indicates the main purpose of the job was:

'To manage staff and resources ensuring safe and effective professional quality care services are provided to all residents within the facility.'

Included in the job description are eight key activities. These include Clinical Leadership, Occupancy Management, Reporting Requirements, Risk Management, Quality, Financial, and Legal and People Management. Each of the key activities has key results and performance measures in place. It appears to be a typical job description for a Clinical Manager's position. No performance reviews were presented.

The Clinical Manager's job was over the whole facility — Hospital, Rest Home and [psychogeriatric unit] wing. [CNM D] noted that she had 54 residents and 50 staff to manage on a daily basis. With the responsibilities of her job, she notes that she worked 60 hours per week. [CNM D] did raise this with management and in her statement she comments that the focus of management was very different to hers. She did not have a performance review/appraisal after the first three months in the position.

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She noted the extra shifts she had to do as management told her not to use agency staff, and she personally fulfilled the roles of RN when needed to. She noted she had little support from her line manager. She also noted that there was a high staff turnover and that hours were reduced due to budget constraints, necessitating that staff worked double shifts.

[CNM D] states that it was not uncommon for her to be contacted overnight up to 3–4 times and for her to receive calls at other times. She would often go to [the rest home] to sort out issues and support staff. She also filled in as a Registered Nurse when needed.

In [CNM D's] first statement, she notes that it is usual practice for the RN on duty to admit a person to the ward. She states she was not informed of any concerns in the first 3 days. In her second statement she states she was away from the 24–28 Dec 2015 and from the 1–4 January 2016 — a total of 8 days over the weekends and statutory holidays. When she was on duty over the holiday period she was working as an RN in the hospital and not involved in the care and management of [Mr B].

[CNM D] states that she had little contact with [Mr B]. She was responsible for contacting family following a letter from the Gerontology Specialist. The second time was after his discharge, when she contacted the Medical Centre to check [Mr B's] weight.

2. Any comments on [CNM D's] oversight of nursing staff and support workers.

[CNM D's] job description clearly outlines her level of responsibility to nursing staff and support workers. This includes conducting education, facilitating regular staff and residents meetings and ensuring clinical records are maintained in line with policies and procedures.

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

Having reviewed all of the clinical notes and statements, I am of the opinion that it was the role of the Clinical Manager to oversee and provide support to the clinical staff — both registered nurses and care workers. However I wish to make note of several issues:

1. In relation to the responsibility and work load for [CNM D], she made several statements about the pressure of work, the overtime required and the need for her to 'fill in on the floor' when staff were sick or did not turn up at work. She also was available to be contacted 24/7 and was expected to attend the facility when she was off duty and on annual leave to address issues.

2. In attempting to fill in and cover and making herself available, she was not able to complete her role as clinical manager. This lack of clinical supervision I believe contributed to the poor care.

It is my opinion that this work load was unsustainable. Obviously providing support for staff and family was important but in so doing, I believe [CNM D] was unable to fulfil

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her role as Clinical Manager. Having identified her concerns to management no action appears to have been taken to address these concerns.

I believe that senior management and directors have a responsibility to ensure health and safety for staff as well as clients. I am of the opinion that appropriate support did not occur and hence [CNM D] was unable to do her job as per her job description.

[RN E]

1. The adequacy of care provided to [Mr B] by [RN E]

Use of Restraints:

[RN E] provided two statements, the first dated 8.3.16 and the second dated 21.2.17. The roster provided by Radius Residential Care shows that [RN E] was on duty for 10 of the 15 days that [Mr B] was at the facility. The shifts ranged from one night shift to AM and PM shifts, including two 12 hour shifts from 7pm–7am.

[RN E] states in his first statement that:

'I was not involved in the process of restraint assessment, discussion with family and consent. The restraint form clearly shows that [Mrs B] signed the form for the potential use of the lap belt.'

In his statement dated 21.2.17, he states his role was that of Restraint Coordinator and that he had been in this role from January 2015. He also states that it was the role of the Health Care Assistants to complete the restraint forms.

The restraint form that is presented in [Mr B's] clinical notes includes a 2 page document titled: Restraint Discussion and Consent. This is a 2 page form with the first page addressing issues around planned outcomes of using restraint, restraint method to be used, risks associated with restraint, assessment as to whether the resident would be safe and finally discussion with family.

In the family area it is written *'family and RN on duty'*. The second page lists the type of restraint and the maximum time frame for the restraint to be used.

The document is signed by [Mrs B] on the 25.12.15 and by [RN E] on the 26.12.15.

As per my previous advice I am of the opinion that restraint cares were poorly managed, very poorly documented and certainly did not meet the standard required. [RN E] was responsible for all restraint practices. In his second statement it is stated that restraint issues were discussed at RN meetings which were attended by the Clinical Nurse Manager. This indicates to me that the practice of health care assistants completing the documentation was common practice and acceptable within the organisation.

I am of the opinion that [RN E] failed to carry out the requirement of the NZS8134.2.2008 in relation to all areas of the requirements from assessment, consent, documentation, monitoring and documentation, and incident reporting. I have assumed that as restraint was discussed at RN meetings, then senior staff and management would

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also have had knowledge of these practices. Policies and procedures clearly outline requirements for Restraint (document number 102) including RN assessment, consultation with other members of the multidisciplinary team, and consultation with family.

It appears that it was common practice for Health Care Assistants to manage and sign issues around restraint Practices. This is completely in conflict with the written policies and procedures that were available at the time.

Quality audits would have identified the failure to follow correct processes. I have thus concluded that such audits were not performed, or if they were, identification of the above issues failed to occur. This indicates a failure within the organisation to identify these practices and to ensure the correct practice was put in place.

I believe that there was a failure to provide [Mr B] with an appropriate standard of care in relation to restraint use and that [RN E] failed to follow correct procedures in relation to restraint use.

I am of the opinion that this would be viewed as a severe departure from acceptable standards by my peers.

Medication:

[RN E] was the Registered Nurse on duty in the psychogeriatric unit and so would have been responsible for cares in relation to medication administration. In his first statement, [RN E] states: '*a decision was made to give him Quetiapine at 08.00 and 1200 to ensure he received his prescribed dose of three times a day'*. It is noted that neither he nor his colleagues contacted the family or the GP for clarification. Therefore, it appears from my examination of signing sheets, that [Mr B] received extra medications.

[Mr B's] condition deteriorated throughout his stay and there is very limited/no evidence that he had a robust assessment of his increasing confusion and poor physical condition throughout his stay. Some of [Mr B's] symptoms, such as his declining mobility, may well have been contributed to by his medication, and this should have been considered as a possible factor in an assessment of his deteriorating condition.

I am of the opinion that medication management was not of an acceptable standard and would be viewed as a moderate–severe departure of acceptable standards by my peers.

Any comments on [RN E's] oversight of nursing staff and support workers.

Responsibility for all cares given to patients in any area of care is the responsibility of the Registered Nurse who is on duty. This responsibility falls into two categories.

The first is the education that Health Care Assistants receive from the facility. The organization is responsible for this. It includes the mandatory training requirements for staff when working in dementia units.

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The second is the direct supervision provided by RNs on duty at each shift. Policies and documentation direct care staff and this is supported by Registered Staff. If the roster is correct then there was an RN on duty for every shift throughout [Mr B's] stay. As the RN on duty, [RN E] had the responsibility to ensure care was delivered to an acceptable standard on his shift. This also applies to other RNs working other shifts.

There certainly appears to be a lack of communication from the Care Staff to the RN. As stated in my original advice there was a lack of systematic review of cares and no identification of reasons for [Mr B's] deteriorating condition, and therefore no alterations to the plan of care to improve the situation.

I believe this would be viewed as a moderate to severe departure from acceptable standards by my peers.

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

All registered nurses working over the time that [Mr B] was in respite, in my opinion, failed to look at the overall clinical picture and to recognise his deteriorating health and needs.

Summary

As previously stated I am still of the opinion that [Mr B] did not receive a high quality of care. Evidence from statements show that two senior staff were away for much of [Mr B's] stay. Policies and procedures were not followed. The facility was short staffed and when senior staff members were working they were filling in other positions and not available to carry out their documented job descriptions.

Organizations must provide a culture where staff are able to fulfil their roles. This must include appropriate training through regular and ongoing education and the provision of adequate support to senior staff."

The following further advice was received from RN Grant:

"I have been asked to provide further comment on the following questions:

1. *In your initial advice you consider that the monitoring and documentation of [Mr B's] bowels was a mild departure from the appropriate standards of care. In light of the information available to the nursing staff at the time about [Mr B's] bowel habits and the bowel records, please advise what steps (if any) the nursing and caregiving staff should have taken in 1 January 2016.*

Nursing staff should have carried out an assessment in relation to bowel habits. This should have included food and fluid intake, a history of his bowel activity including last bowel movement, the type of bowel movement, and a list of his medications, with particular reference to any which may have affected bowel activity.

It is noted that [Mr B's] clinical records state his bowels opened on the 31.12.15.

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2. *If the Deputy Commissioner was to find that a manual bowel evacuation (digital insertion) occurred on 1st January 2016 to help enable a bowel movement (as opposed to the anal area being massaged) would this cause you to amend your level of departure from the appropriate standard of care.*

It is my opinion that if the Deputy Commissioner finds that there was a manual bowel evacuation (digital insertion) that occurred on the 1st January, then the departure from an acceptable standard would be considered a severe departure. As previously noted in my advice the documentation lacked consistency and there are conflicting and different accounts of this event. His clinical notes, however, indicated that he had a bowel motion on the 31.12.15 and so there is no clinical indication to suggest a manual bowel evacuation the following day was justified.

No invasive procedure should have been done by care staff at any time.

3. *Please comment on [Mr B's] weight loss during his respite stay. As you have noted in your advice, there is a factual dispute as to the amount of weight loss that [Mr B] sustained. We would be grateful for your general advice regarding weight loss: A) what level of weight loss (if any) is acceptable and B) what level of weight loss would be considered a mild, moderate and severe departure from appropriate standard of care?*

A) [Mr B] was in [the rest home] for a very short time — 2 weeks. In the event that he had no acute medical issues it would not be expected that he would lose weight, or if he did it would be expected to be minimal. He was admitted from home where he had had nutritional drinks to ensure he maintained his weight. In addition, his weight prior to admission was around 58–59kgs (from information provided at the time of my first report concerning [Mr B]). A number of red flags should have been apparent at the time of his admission.

He had a lowish body weight for which he was receiving nutritional supplements. He was a type 2 diabetic on oral medication.

One would thus expect to see close monitoring of his food and fluid intake, and more frequent recordings of weight if there were any concerns around his daily intake.

In the event that he did lose weight, then one would expect to see an assessment to identify why he had lost weight and was continuing to do so. One would also expect to see measures put in place to try and maintain a good daily food intake eg continuing provision of the nutritional supplements given at home.

B) Again depending on his medical issues, general health and timeframe, two weeks is a very short interval in which to lose an excessive amount of weight. Obviously if a patient is not eating or drinking then he will lose weight at a far greater rate. [Mr B] was not a big man on admission so any weight loss, in my opinion, would have been very obvious for staff to detect.

BMI (Body Mass Index) is a measurement system used to identify weight loss. Although I do not have the clinical notes to view, I do not think that his BMI was

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measured, hence it is difficult to comment. What is important is the establishment of a baseline weight on admission and continuing assessments and interventions when it is observed that a patient is losing weight.

Family, medical, nursing staff and dieticians should be involved in the assessment process. It is not uncommon for nursing staff to see a clinical change in a patient after a loss of say 3kg over a period of a month. [Mr B] was only in the facility for 2 weeks, and in that time his clinical picture changed quite quickly. The clinical notes do indicate that he was not eating and drinking, and that he appeared to become very frail and unable to mobilize. It is my opinion that his weight loss should have been easily and quickly detected.

The family believe [Mr B] lost 17kg in weight from the time before he was admitted to [the rest home] to the week he returned home. If he did lose this amount of weight, then it is an excessive weight loss in a short period of time and should have been immediately apparent. This again highlights the importance of accurate weight recordings on admission to establish a baseline against which changes may be determined.

I do not feel that I can comment on what would be an acceptable weight loss in terms of mild, moderate and severe departure from acceptable standards without looking at the overall clinical and care picture, and the assessments and interventions that staff put in place. I feel this is documented in my opinion of the case."

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