Rowena Jackson Retirement Village Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC01735)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a man at Rowena Jackson Retirement Village in 2018, in particular the management of his pain.

2. The man was agitated and complained of a painful upper thigh. There was no evidence that the man had had a fall. The caregiver reported the man's pain to the registered nurse, but the nurse did not commence a pain assessment tool or pain observation chart.

3. The following day, the man continued to complain of pain in his left leg, and another registered nurse and the Unit Coordinator were contacted. Again, neither the nurse nor the Unit Coordinator used a pain assessment tool. At 11.08am, a pain assessment tool was used, but the assessment was incomplete. A fax was sent to the GP for pain medication and "something for behaviour", but staff did not request a GP review. The man continued to deteriorate and his pain worsened. The registered nurse then sent a second fax to the GP requesting a review, but this fax was not received by the GP.

4. An enrolled nurse working on the afternoon shift did not use a pain assessment tool or conduct a pain assessment, and did not complete any observations. No one followed up with the GP on this date and, as a result, the GP did not attend the rest home.

5. Staff continued to review the man but did not use a pain assessment tool. The man deteriorated further, and the registered nurse contacted the GP again and was asked to re-send the fax sent the previous day. The nurse re-sent the same fax but did not provide any new details about the man's deteriorating condition. Later that day, the GP reviewed the man and discovered that he had not been weight-bearing for two days. The GP diagnosed a fractured left neck of femur,[1] and the man was transferred to hospital via ambulance.

Findings

6. The Deputy Commissioner found that Rowena Jackson Retirement Village Limited did not provide appropriate care and services to the man following the discovery of his left leg pain. Multiple staff failed to use an appropriate pain assessment tool and did not monitor the man's pain adequately. There was a lack of urgency in obtaining a GP review, no referral or attempt to transfer the man to hospital was made following the delayed GP review, and written communication with the man's GP was inadequate. Accordingly, the Deputy Commissioner found that Rowena Jackson Retirement Village Limited breached Right 4(1) of the Code.

Recommendations

7. In her provisional decision, the Deputy Commissioner recommended that Rowena Jackson Retirement Village Limited apologise to the man's family, and an apology was provided. The Deputy Commissioner also recommended that Rowena Jackson Retirement Village

[1] Hip fracture.

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Limited audit compliance with its falls management plan and the use of the new ISBAR fax template and the amended fax referral document.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a referral from the Coroner about the services provided to Mr A (dec) at Rowena Jackson Retirement Village. The following issue was identified for investigation:

- *The appropriateness of the care provided by Rowena Jackson Retirement Village Limited to Mr A in Month1*[2] *2018.*

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

10. The parties directly involved in the investigation were:

Provider/Deputy Operations Manager	
Mrs A	Consumer's wife
Mr A's daughter	
RN B	Provider/registered nurse
RN C	Provider/registered nurse
Dr D	Provider/general practitioner (GP)
RN E	Provider/registered nurse

11. Also mentioned in this report:

EN F	Enrolled nurse

12. Information from the Coroner and the district health board was also reviewed.

13. In-house expert advice was obtained from Registered Nurse (RN) Hilda Johnson-Bogaerts (Appendix A).

[2] Relevant dates are referred to as Months 1–3 to protect privacy.

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Information gathered during investigation

Introduction

14. At the time of these events, Mr A (aged in his seventies) resided at Rowena Jackson Retirement Village. Rowena Jackson Retirement Village is owned and operated by Rowena Jackson Retirement Village Limited (Rowena Jackson).

15. In 2012, Mr A was diagnosed with probable mixed,[3] vascular,[4] or Alzheimer's[5] dementia, hypertension,[6] a hearing impairment, GORD,[7] and dyslipidemia.[8] He had a five-year history of cognitive decline, with some paranoid ideation over the previous two years. As a result, Mr A also had behavioural issues, and sometimes he could be confrontational with staff.

16. Mr A's wife was his attorney appointed under an activated Enduring Power of Attorney for health and welfare.

17. Mr A was cared for at home by his wife until 2016, when he was admitted to a care facility.[9] He resided there until 21 Month1, when he was transferred to Rowena Jackson Retirement Village and admitted to the secure dementia unit.

21 Month1 — admission to Rowena Jackson Retirement Village

18. On 21 Month1, a registered nurse completed a Nursing Assessment and Care Plan. It noted that Mr A's Coombes Score[10] was 11 (a medium risk of falls). Mr A was also noted to be mobilising independently, with good balance, and no history of falls was noted during the admission process. The initial nursing care plan intervention for mobility directed staff to report any changes in mobility to the registered nurse.

19. Rowena Jackson told HDC that at that time, pain assessments were recorded in an electronic resident management system called VCare, and included the Abbey Pain Scale.[11] Rowena Jackson stated that this is completed for all residents on admission, and then as required. Mr A's baseline Abbey Pain Scale, completed on 21 Month1, indicated no signs of pain.

[3] Mixed dementia is a condition in which brain changes of more than one cause of dementia occur simultaneously.
[4] Vascular dementia is a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain.
[5] Alzheimer's is a progressive disease in which dementia symptoms gradually worsen over a number of years.
[6] High blood pressure.
[7] Gastro-oesophageal reflux disease (also known as acid reflux, GORD, or GERD) describes inflammation of the lining of the oesophagus owing to stomach acid leaking upwards from the stomach.
[8] An abnormal amount of fat in the blood.
[9] A care facility offering rest-home services, short- and long-term stays, and respite and carer support.
[10] A tool used to assess the risk of falling.
[11] The Abbey Pain Scale is an instrument used to assess pain in patients who are unable to articulate their needs clearly.

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20. On 22 Month1, Dr D, Mr A's GP, saw Mr A and attended to his medical admission and the prescription of his medications.

Night shift on 25 to 26 Month1

21. At 6.30pm on 25 Month1, a registered nurse noted on the behaviour chart that Mr A had been verbally abusive and agitated, but the cause was unknown. The nurse documented that staff responded to his behaviour by not showing any negative emotion. Subsequently, the nurse noted in the behaviour chart that Mr A remained agitated but this did not escalate, and over time he "got distracted and forgot".

First review by registered nurse

22. At 11.30pm on 25 Month1, a caregiver documented in the progress notes that Mr A was very agitated, verbally abusive to staff, and pushing staff from behind. She noted that she telephoned RN E to check whether Mr A had any PRN (as required) medication charted.

23. RN E stated that at 11.50pm she was asked to attend because Mr A was agitated. At 12am, RN E documented in the behaviour chart that Mr A was being physically aggressive and following staff around. RN E told HDC that Mr A did not have PRN medications charted to assist with this kind of behaviour so, for safety, RN E advised the staff to move away from Mr A and to monitor him.

Second review by registered nurse

24. The caregiver recorded in the progress notes (untimed) that Mr A went to his room and sat on a chair. She did not note specifically when this action occurred. She recorded that she asked him whether he would like to get into bed, but noted that he "was verbally [abusive]", so she left him. She documented that she returned twice at 10-minute intervals to ask him whether he would like to get changed for bed, and when she asked him to stand up, he said that he could not walk and complained of a painful upper thigh. The caregiver recorded that she contacted RN E again and asked her to assess Mr A.

25. RN E told HDC that she attended Mr A again at 1am on 26 Month1, as she had received a telephone call from the caregiver about his pain. At 6am, RN E documented in the progress notes retrospectively that she had assessed Mr A and found him to be very agitated. She noted that at 1am she had reviewed Mr A and he had told her that his left thigh was sore and he could not move, but she could see no apparent bruising or redness, and he had no pain on palpation. RN E recorded that Mr A refused a heat pack when offered, and that no medications were charted for pain, and he was put back to bed slowly, and he settled at 1.30am and slept well. RN E also documented in the behaviour chart that she asked Mr A to go to his bedroom, and that at 1.30am he was settled in bed.

26. At 8am, RN E documented in the behaviour chart that to reduce Mr A's current behaviour they had "shut the door and left the room", and that at 9.10am Mr A was still unsettled. RN E said that she was not contacted again during the shift.

27. RN E did not complete an Abbey Pain Scale assessment or use any pain assessment tool, and acknowledged to HDC that this should have been commenced at the time. She said

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that she had not attended in-service training on pain assessment and management in the previous two years, but had completed the Registered Nurse Induction Course as part of her initial training (this induction training was completed in 2015, around 2.5 years earlier).

Care provided on 26 Month1

Morning shift

28. RN C was working on the morning shifts of 26 and 27 Month1. At 9.10am on 26 Month1, RN C noted in the progress notes that a caregiver reported that Mr A was aggressive and abusive towards staff. She recorded that she went into Mr A's room to prepare his breakfast and his morning medications, but Mr A refused his medication and "was very abusive". RN C told HDC that there was no evidence that Mr A had fallen, and that when she saw him, he was verbally abusive and agitated, which she thought was a behavioural issue.

29. RN C said that she "could not get near to [Mr A] to do [her] own assessment and felt out of her depth, so [she] contacted the unit coordinator", RN B,[12] who came to assess Mr A. It was not recorded when RN B reviewed Mr A, and RN B did not document anything in the progress notes. RN C made the following untimed entry:

> "[Mr A] seems to be in a lot of pain, L[eft] groin [and] lower leg, Pedal oedema[13] L[eft] foot and ankle poor mobilising from chair — had to put him in a wheel chair to get to the toilet."

30. RN B told HDC that RN C told her that Mr A was highly agitated and would not allow cares, and requested that RN B help to try to calm him. RN B said that RN C told her that Mr A had been following the night staff around and trying to "ram" into them with the linen trolleys. RN B stated that RN C did not tell her that there were issues with Mr A's mobility or pain, but instead that RN C indicated that he had been mobilising overnight.

31. RN B told HDC that when she reviewed Mr A, he was lying on his bed and had been incontinent of urine and had wet clothing and bedding. She said that he was not agitated but could not answer questions clearly. She stated: "[Mr A] was muddled with his speech and he did not say he was in pain." RN B told HDC that she suggested to Mr A that he be changed into dry clothes and have some breakfast. She said that when she assisted him to sit up, his hand went to his lower back, and he grimaced and rubbed his penis. She asked him whether he was sore, and he said that he was.

32. RN B told HDC that she then advised RN C that Mr A appeared to have a sore lower back and penis, and queried whether he might have an underlying urinary tract infection (UTI). She asked RN C to investigate further and, as there was inadequate analgesia charted for Mr A, to refer him to his GP.

[12] RN B told HDC that on the morning of 26 Month1, she was informed by a fellow nurse that she would be working as the Acting Unit Coordinator that day. She said that this was her first time in the role.

[13] Accumulation of fluid in the feet and lower legs.

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33. Rowena Jackson told HDC: "Although [RN B] did not perform a comprehensive pain assessment, it was evident that [Mr A] had pain in his back, groin and down his left leg."

34. RN C told HDC that she was not in the room when RN B assessed Mr A, because of the acuity on the unit. RN C stated: "[RN B] had another staff member with her in the room. [RN B] on assessment did not find any reason/evidence of injury for [Mr A's] pain."

35. RN B told HDC that she left RN C to follow up her advice, as RN C was Mr A's primary nurse. RN B said that she then left the dementia unit but returned shortly afterwards to review Mr A again, and by that time he was dressed and sitting in his chair having breakfast. She stated:

> "[Mr A] was calm, in no way agitated and showed no facial expression, moaning or guarding behaviours indicative of pain. [RN C] did not inform me of any additional concerns with mobility or pain."

First fax to GP

36. RN B told HDC that around morning tea time, she returned to the dementia unit to see whether RN C had been able to contact Mr A's GP. RN B said that RN C had started to send a fax to the GP but had been called away to another resident, so she (RN B) completed the fax with information regarding Mr A's behaviour and what she had seen earlier regarding his pain.

37. The fax was marked "urgent" and signed by RN B, but the time it was sent is not recorded. The fax states:

> "[Mr A] has been aggressive and non-cooperative … we have assessed underlying pain in L[eft] leg and lower back — no known causative incident, no signs [of] injuries. Pain appears mod[erate]–severe and is limiting mobility. Would you please urgently chart PRN analgesia and something for behaviour … Addition: significant [left] pedal oedema[14] …"

38. RN C noted in the progress notes that a fax had been sent to the GP for urgent medication for pain and behaviour, and that she was awaiting a response.

39. Dr D told HDC that he received the fax at 8.36am, and the fax did not note any injury or request for a review or a visit. He stated that the usual process is that if Rowena Jackson Retirement Village contacts him by fax, he responds by fax advising when he will come to review the patient. If the request is marked as urgent, usually he attends to it during his lunch break. If more acute, he will ring and advise staff that it is more appropriate that the patient be transported to hospital.

40. Dr D stated that although hip fractures are always possible in the elderly, he specifically noted that the nurses had not detected any signs of injury, and there was no known

[14] Swelling.

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causative incident, so he charted midazolam[15] nasal spray for Mr A's aggressive behaviour, and paracetamol for his pain.

41. RN B told HDC that she checked on Mr A again, and he appeared comfortable at that time. He was having a cup of tea and a sandwich and smiling. She said that his behaviour was settled and calm, and he was showing no behaviour that would indicate pain. RN B did not document this in the progress notes.

Second fax to GP

42. RN C noted that Panadol was charted and given to Mr A at 11.04am, but that its effect did not last for long. Mr A still had pain in his left leg and could not mobilise. RN C took Mr A's vital signs and noted a temperature of 37.6°C,[16] an oxygen saturation of 94%,[17] a heart rate of 121 beats per minute (bpm),[18] and blood pressure of 118/70mmHg.[19] RN C said that after discussion with RN B, a decision was made that Mr A needed an urgent GP review.

43. RN C told HDC that she faxed the GP and noted Mr A's observations. The fax did not record the time it was sent. It stated:

> "Wondering if you could please come out and review [Mr A]? Due to his pain levels [and] pedal oedema. Has got worse throughout the day … He cannot stand or mobilise without severe pain. If you could see him [as soon as possible] that would be great. Kind regards, [RN C]"

44. RN C documented in the progress notes (untimed): "[F]axed GP to come out and review [Mr A] due to his sudden pain in left leg." RN C said that she "was contacted by the Doctors office via a phone call and that [Dr D] would come out to review Mr A that afternoon". RN C cannot recall whether it was the nurse or the receptionist from the medical centre who called her. She stated: "[U]sually it is just the receptionists that pass on the message that the Doctors are coming. The Doctors very rarely ring themselves." RN C did not document the precise time at which the fax was sent to the GP's office, or what was discussed and with whom.

45. Dr E said that he was not aware of this fax, and told HDC:

> "I cannot recall any conversation taking place on 26 [Month1] … I always document calls with health care providers in the clinical notes. There is no record of such conversation in the notes."

46. Mr A's progress notes also contain no record of a telephone conversation with the medical centre.

[15] Medication used to relieve anxiety.
[16] Normal body temperature is around 37°C.
[17] Normal oxygen level is at least 95%.
[18] Normal resting heart rate for adults is 60–100bpm.
[19] Ideal blood pressure is between 90/60mmHg and 120/80mmHg.

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47. RN C documented in the progress notes that she contacted Mr A's wife about seeking a GP review, but did not note the time at which discussion with the family occurred. RN C recorded that Mrs A told her that the oedema in her husband's left foot had been present since November 2017, but that the pain and decrease in mobility was new, and she was happy for the GP to review him.

48. RN B stated: "As far as I was aware, [Mr A] remained comfortable and settled throughout the shift. I was not made aware of any further presentations of pain or any difficulty mobilising."

49. At 11.08am, RN C commenced a pain assessment using the Abbey Pain Scale. The assessment is incomplete, but she recorded in the progress notes: "Nurses documented overnight [Mr A] reporting pain in left leg/thigh. Nothing visible at thigh or lower leg but left pedal oedema."

50. Following RN C's 11.04am entry that Panadol had been administered, there are no further entries in the progress notes until 9.50pm. RN C told HDC that she handed over to the afternoon staff that the GP would be out to see Mr A that afternoon. No further observations (vital signs or pain assessments) were documented for the remainder of the morning shift or during the afternoon shift.

51. Rowena Jackson told HDC that on this day:

> "[RN C] should have completed repeat observations after her initial morning ones, and this would have indicated a need for increased urgency for the GP review. [RN B] could also have followed up before she went off duty that afternoon. Both RNs regret the lack of follow up."

26 Month1 — afternoon and evening shift

52. Enrolled Nurse (EN) F told HDC that she looked after Mr A during the afternoon shifts on 26 and 27 Month1. She stated that she works as the senior caregiver on shift in the afternoons, as no registered nurse is on duty in the unit, and it is overseen by the registered nurse in the hospital wing.

53. At 9.50pm on 26 Month1, EN F recorded in the progress notes that Mr A was settled but remained in a wheelchair all evening and declined to elevate his left leg. She noted that Mr A's left leg was swollen, and that he had pitting oedema, pain on movement, was unable to weight bear, and required two assistants and a transfer belt to transfer from the wheelchair to the toilet. EN F also documented that Mr A participated in games and was settled in the lounge watching cricket.

54. EN F stated that RN C had told her that the GP would arrive after his medical centre hours and, by the time she realised that the GP had not come to see Mr A, it was too late to contact him. EN F did not document the detail of the handover from RN C. EN F stated: "We can't contact the GP out of hours and [Mr A] was settled in bed by this stage. I

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diarised for follow up first thing in the morning." She noted in the progress notes: "Nil contact or visit from [Dr D]. Diarised to follow up in the AM."

55. EN F noted in the progress notes that at 10.30pm Mr A was still in the lounge, that he declined to go to bed, and that his legs were elevated on the foot stool. EN F noted at 10.45pm that Mr A had asked to go to the toilet and was unable to weight bear on his left leg. He required two assistants to transfer to the toilet, and he was then transferred to bed. The progress notes also document that EN F installed a sensor mat on the floor, and that Mr A engaged in conversation all shift and there were no behavioural issues.

56. Overnight, a night staff member retrospectively noted in the progress notes at 6.30am that Mr A required two assistants to use the toilet, and he was dribbling and sweating, and staff noted that he had a small graze on his left arm. It was also noted that a registered nurse was informed about Mr A's condition, but not when this occurred, and there is no record of a review by a registered nurse during the night shift.

Information from Rowena Jackson about care provided on 26 Month1

57. Rowena Jackson stated that EN F should have followed up with the GP earlier and completed repeat observations after the initial morning ones, which would have indicated a need for increased urgency for the GP review.

58. Rowena Jackson told HDC:

> "No further observations including vital signs or pain assessment were documented for the remainder of the morning shift, or afternoon shift. Given [Mr A's] increased heart rate and slightly elevated temperature at 11am, his vital signs should have been rechecked by both [RN C] and by [EN F] on afternoon shift."

59. Rowena Jackson stated:

> "It would have been appropriate for the pain assessment to be repeated throughout [26 Month1] and although informal assessments were made, they were not documented as per [its pain] policy."

27 Month1

60. Mr A's next set of vital signs was taken by RN C at 9.20am on 27 Month1. RN C documented in the progress notes that Mr A was slightly febrile at 37.4°C, with a heart rate of 122bpm, which was unchanged from the previous day. Staff noted in the progress notes that Mr A appeared grey and sweaty, and that his foot was hot to touch.

61. RN C said that when she returned to work on the morning of 27 Month1, she was "shocked to find that nobody had reviewed" Mr A. She noted in the progress notes that she telephoned the GP's office and spoke to the nurse, who asked her to re-send the urgent fax, and said that she would take it to the GP personally. The same copy of the second fax (with no additional information) is marked "Re-faxed as requested 27 [Month1] 1030hrs".

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62. RN C told HDC that she explained to the medical centre nurse that Mr A needed to be seen, and that he appeared to have an infection, as he was sweating and his temperature and heart rate were elevated. RN C stated that she told the nurse that she had discussed with Mr A's family whether he should be sent to hospital, and the family was happy to keep him on site if he could be seen by the GP. RN C documented in the progress notes that the GP would "visit after work tonight". RN C told HDC that the medical centre nurse telephoned back and confirmed that the GP would definitely be there that day. RN C said that RN B had been over to the unit and was happy with the GP coming that day.

63. RN C recorded in the progress notes (untimed) that she updated the family. She told HDC:

> "[S]taff and family were all happy with the plan in place. When he was not seen on the first day, I contacted the GP, I spoke to the Unit Coordinators and the Village Manager. I feel like I escalated my concerns to the right people and it was believed that [Mr A] could be treated on site believing it was an infection."

64. The same fax was sent back to Rowena Jackson Retirement Village from the medical centre with a written note added: "[Dr D] will visit after work tonight."

65. Rowena Jackson stated: "In hindsight … it would have been more appropriate for an ambulance to be called when [Dr D] did not review [Mr A] as planned."

Review by Dr D

66. EN F noted in the progress notes that Dr D reviewed Mr A at 5.30pm.

67. Dr D told HDC that he visited Mr A on the evening of 27 Month1 and noted his history of non-weight-bearing since the morning of 26 Month1, and the absence of a history of a fall. Dr D said that Mr A had bilateral leg swelling, and his left leg was lying in external rotation. Mr A's hip was very painful with movement. Dr D diagnosed a left neck of femur fracture.[20] He spoke to the Emergency Department at the public hospital and arranged for Mr A to be transferred.

68. Dr D stated that the initial fax had understated the degree to which Mr A was incapacitated and, when he visited, he discovered that Mr A had been non-weight-bearing for two days, whereas the fax stated only that the pain was limiting his mobility. Dr D said that if a review had been desired, it should have been requested formally, rather than only a request to chart medications with reference to left pedal oedema at the end of the fax.

69. Rowena Jackson stated that it actively encourages staff to engage with ambulance and hospital services if indicated. It said that its policy "Accident and Emergency Services" directs nursing staff to refer residents to hospital if they are unwell and a GP is not able to come to assess them.

[20] Hip fracture.

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Subsequent events

70. Mr A was transferred by ambulance to the Emergency Department accompanied by his wife. He arrived at the hospital at 7pm. A consultant geriatrician told the Coroner that Mr A was investigated and that a left neck of femur fracture was confirmed on imaging, and Mr A was provided with appropriate analgesia including a femoral nerve block.[21]

71. Mr A was admitted to the Orthopaedic Ward at 6.45am on 28 Month1. He was also diagnosed with left-sided pneumonia[22] and commenced on antibiotics.

72. On 29 Month1, Mr A underwent a left hemiarthroplasty[23] under general anaesthesia. However, his clinical condition deteriorated during the first two days following surgery, and he died on 8 Month2.

Investigation report

73. Rowena Jackson conducted an internal investigation, which was completed in 2018. The report notes that the period of time from when Mr A initially complained of pain in his left thigh until he was seen by the GP and transferred to hospital was approximately 42 hours. There was no indication of a fracture from the first nursing assessment, but during the period 26/27 Month1, there was a significant change in Mr A's health status. His mobility declined and he was observed to be unable to weight bear.

Further information

Fax

74. Rowena Jackson told HDC that because of the lapse in time, fax records are not retrievable. Dr D advised that he does not have any electronic recording of the faxes between 26 and 27 Month1.

Rowena Jackson

75. Rowena Jackson stated:

> "On further reflection at an individual and organisational level, we have all learnt and grown from the review of [Mr A's] presentation and care. Professional growth has been acknowledged in the statements provided by the RNs who cared for [Mr A]. [Rowena Jackson] commits to reviewing and adding to policies and procedures to ensure that our residents receive the most appropriate care."

RN B

76. RN B told HDC that as she had been told that Mr A was mobilising freely overnight, and as she was not made aware of any further pain or difficulty mobilising after her initial visit to him, she did not consider the possibility of a hip fracture. She stated that each time she saw Mr A after the initial visit, he appeared comfortable, settled, and stable. She said that

[21] Local anaesthesia for relief of pain.
[22] Infection of the lung.
[23] A surgical procedure to treat a fractured hip.

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prior to this, she had not encountered a resident who was able to mobilise with a fractured hip or presented with lower back pain or penile pain.

77. RN B stated that she had not attended any specific education sessions related to referral and escalation of care, but those aspects were part of her Registered Nurse Induction and Responsibilities training.

RN C

78. RN C stated:

> "Reflecting back on this incident I wish that I had just sent [Mr A] to [hospital] to be checked over. I apologise for the time delay … and this has changed my nursing practice immensely. I will never hesitate to get a patient checked and will follow my gut instinct more. At the time I believed we were all doing the right thing but in hindsight I wish we got [Mr A] assessed quickly and will ensure that the time delay in my nursing care will never happen again."

EN F

79. EN F stated:

> "I have reflected on my care and if I was caring for a resident like [Mr A], I would have done things a bit differently. I would have read his notes more and done some vital signs … I am very sorry that I did not do these things and I have been focusing hard on improving from this. Over the last year and a half I have been focusing on my nursing assessment skills by regularly filling in [RN] shifts, ensuring I am very thorough with each assessment of my resident and getting another nurse to also check/assess my decisions."

Changes made since incident

80. Rowena Jackson told HDC that as a result of this incident, it addressed issues and made improvements, including the following:

a) Further education, including the assessment and management of pain, was provided to all registered and enrolled nurses.

b) A quality improvement plan that involved workshops for registered and enrolled nurses was provided, and specific in-service "case study" days were delivered by the Clinical Manager to 20 nursing staff (including those who had worked with Mr A) in 2018.

c) In 2018, education on vital signs was delivered nationally to all registered nurses, enrolled nurses, and caregivers. The in-service education reinforced the importance of taking observations and identifying anything outside "normal" limits, and the appropriate follow-up.

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d) In 2018, a Registered and Enrolled Nurse Journal Club on assessing the unwell patient encouraged critical thinking around which observations and assessment should be considered to identify a resident who requires further intervention.

e) Because the generic fax referral document does not lend itself to a problem-orientated communication style, it has developed a document using the ISBAR[24] format. Rowena Jackson told HDC: "While this tool has been taught to our nurses over the years and its use has been encouraged, we had not created this as a formal document. We acknowledge it would be appropriate to formalise the use of this tool and a policy on this will be released on 1 October 2019."

f) It has developed a new policy, "Assessment and Management of the Acutely Unwell Resident", which will be released to all villages with further education. The policy outlines the use of the new fax template and guides nurses on sending residents to hospital.

81. In response to the provisional report, Rowena Jackson told HDC that since these events it has introduced additional registered nurse support in the dementia unit in the form of a specifically appointed Unit Coordinator. Rowena Jackson also told HDC that following receipt of the provisional report, it undertook the following:

a) Further education and training for staff at Rowena Jackson on pain assessment and the use of an appropriate pain assessment tool. A copy of the Education Attendance Record was also provided.

b) A review of its training schedule for registered and enrolled nurses, particularly regarding pain assessment, nursing assessments, and clinical diagnosis, and with a focus on dementia, accessing further medical assistance, and transferring residents to hospital.

c) A review of the application and appropriateness of the new policy "Assessment and Management of the Acutely Unwell Resident", and further education for staff on the policy.

Responses to provisional report

Mr A's daughter

82. Mr A's daughter was provided with an opportunity to comment on the "information gathered" section of the provisional decision and had no comments to make.

Rowena Jackson

83. Rowena Jackson was provided with an opportunity to comment on the provisional report. Where appropriate, its comments have been incorporated into the report. Rowena Jackson said that in Month2 it was audited by the Ministry of Health and fully attained all the standards required. Rowena Jackson disagrees that there were systemic failures or a

[24] The ISBAR communication framework is used to create a structured and standardised communication format between healthcare workers. ISBAR stands for Identification, Situation, Background, Assessment, and Recommendation.

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culture of poor or non-compliance. Rowena Jackson provided HDC with records of staff compliance with the Pain Policy around the time of this incident, including completion of objective pain assessments both routinely and acutely as required.

84. Rowena Jackson told HDC:

> "[Rowena Jackson] again extends its sincere apologies to [Mr A's] family. Rowena Jackson acknowledges it was responsible for [Mr A's] care and, as you are aware, the staff involved have since reflected on their clinical response, including assessment and actions. Rowena Jackson has also taken steps to address the issues that arose in relation to [Mr A] …
>
> We acknowledge the finding of a breach. [Mr A] should have had his pain assessed in accordance with Rowena Jackson's documented Pain Policy and should have been transferred to hospital earlier in accordance with the documented Accident and Emergency Services Policy and we are very sorry that this did not occur."

Rowena Jackson policies

Falls policy

85. The "Falls Prevention" policy (2016) provides a number of person-specific risk factors for falls. It states that person-specific risk factors need to be assessed and identified for each resident, and suitable interventions incorporated into the resident's care plan. A number of environmental risks are listed.

86. The policy states that the Coombe Assessment for Predicting Fall Risk and the care plan are to be assessed six monthly, but may need to be reviewed at an earlier date if a fall has occurred and significant change is identified. The policy also lists a number of falls-prevention interventions.

Accident and emergency policy

87. The "Accident and Emergency Services" policy (November 2016) states:

> "If medical services beyond basic first aid are needed, the RN or senior caregiver in charge is responsible for contacting a doctor and/or [ambulance service] for transfer to the nearest general hospital with the appropriate facilities."

Pain policy

88. The Pain policy (December 2016) states:

> "Procedure
>
> Assess all residents for presence of pain … if a resident report[s] that they are experiencing symptoms of pain and/or there is evidence of behavioural cues indicative of the presence of pain …

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The Registered Nurse (RN) will ensure the appropriate documentation related to comprehensive assessment, planning and evaluation is detailed and remains current. This will ensure that the regime is effective.

— The RN will assess the resident's ability to use a pain rating scale

— The resident's pain will be assessed using the pain assessment evaluation (initial assessment) or Abbey Pain Scale (for residents with dementia who cannot verbalise their pain) …

Staff will also monitor the response to pain interventions (eg medication and positioning devices) half hourly after the administration/provision of treatment … When the resident's pain is reassessed, this will be documented (including the resident's response) in the Pain Assessment Evaluation (ongoing evaluation) or Abbey Pain Scale."

Relevant standards

89. The Health and Disability Sector Standard, NZS8134.1.2: 2008 (NZHDSS) states:

"Service management Te Whakahaere Ratonga

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

…

Quality and risk management systems Punaha Whakahaere Kounga, Tirotiro Whakararu

Standard 2.3 The organisation has an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles."

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Opinion: Rowena Jackson Retirement Village Limited — breach

Introduction

90. As a healthcare provider, Rowena Jackson Retirement Village Limited is responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). This duty includes a responsibility to operate the facility in a manner that provides its residents with services of an appropriate standard in accordance with Right 4 of the Code.

91. The NZHDSS requires that rest homes ensure that the operation of their services are managed in an efficient and effective manner to ensure that they provide timely, appropriate, and safe services to consumers.[25]

92. The issues with the care provided on 25 to 27 Month1 were not related to isolated incidents involving only one staff member, but rather were repeated actions or omissions involving a number of different staff members. While there is individual accountability for these actions, in my view the various failures in this case by a number of different staff caring for Mr A over these two days reflect a pattern of poor compliance with policies at Rowena Jackson in relation to the care provided to him on 25 to 27 Month1. I consider that Rowena Jackson had the ultimate responsibility to ensure that Mr A received care that complied with NZHDSS and the Code.

93. This opinion considers whether Mr A was provided with services of an appropriate standard, in particular the care provided following the discovery of his left leg pain on 25 Month1.

Pain assessment

94. At 11.50pm on 25 Month1, the caregiver on duty contacted RN E because Mr A was agitated, physically aggressive, and following staff around. RN E advised staff to move away from Mr A and to monitor him. Mr A went to his room and sat on a chair. The caregiver returned twice at 10-minute intervals and, when she asked Mr A to stand up so that she could get him ready for bed, he said that he could not walk, and complained of a painful upper thigh. He did not say that he had fallen, and no staff reported having seen a fall or having found him on the floor.

95. At 1am on 26 Month1, the caregiver contacted RN E again. Mr A told RN E that his left thigh was sore and he could not move, but RN E was unable to give pain relief because Mr A had no PRN medication charted for pain. RN E did not commence a pain assessment tool or pain observation chart in accordance with Rowena Jackson's pain policy to monitor Mr A's progress.

[25] NZS 8134.1:2008, Standard 2.2.

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96. My in-house aged-care expert advisor, RN Hilda Johnson-Bogaerts, stated that at this stage, "no objective pain assessment tool was used or pain observation chart commenced which would have been appropriate to monitor progress".

97. On the morning of 26 Month1, RN C was told that Mr A had complained of pain in his left leg. She said that as there was no evidence that he had fallen and he was verbally abusive and agitated, she thought that it was a behavioural/aggression issue. RN C contacted the Unit Coordinator, RN B, who assessed Mr A and noted that he seemed to be experiencing a lot of pain in his left groin and lower leg. RN B did not use a pain assessment tool as required by Rowena Jackson's pain policy.

98. At 11.04am on 26 Month1, RN C gave pain relief (Panadol) to Mr A. At 11.08am, RN C commenced a pain assessment using the Abbey Pain Scale, but the assessment was incomplete. RN C did not document any further observations, including vital signs or a further pain assessment, for the remainder of the morning shift.

99. EN F worked the afternoon shift on 26 Month1. EN F did not make any documentation during her shift until 9.50pm. She noted that Mr A was settled but remained in a wheelchair all evening, declined to elevate his leg, and his left leg was swollen. EN F also noted that Mr A had pain on movement, and was unable to weight bear and required two assistants and a transfer belt to transfer from the wheelchair to the toilet. However, EN F did not use a pain assessment tool or conduct a pain assessment as required by Rowena Jackson's pain policy, and did not complete any observations.

100. RN C reviewed Mr A on the morning of 27 Month1 but did not use a pain assessment tool in accordance with Rowena Jackson's pain policy. EN F was on the afternoon shift, and similarly did not use a pain assessment tool.

101. Rowena Jackson's pain policy states that the registered nurse will assess the resident's pain using a pain rating scale, and that for residents with dementia who cannot verbalise their pain, the pain assessment evaluation or the Abbey Pain Scale is to be used.

102. RN Johnson-Bogaerts advised that observations and pain assessment should have been repeated at least three times per day. She stated:

> "There was no objective pain assessment tool used to assess and document the severity of [Mr A's] pain which may have contributed to the underestimation of his pain. While assessing pain in older adults with dementia can be complicated because of the changes in the person's ability to communicate verbally … [t]here are however good objective tools that can be used."

103. RN Johnson-Bogaerts advised that Rowena Jackson has "a good pain assessment tool and procedure", but it was not adhered to. She said that it would have been good practice for a pain assessment tool to have been used and for a pain observation chart to have been commenced, to document systematically how Mr A's pain symptoms changed over time and across shifts.

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104. RN Johnson-Bogaerts advised:

> "The nurse's assessments included a rough description of the behaviour he presented … It would have been appropriate to also assess limitation in movement or pain when moving. These observations should have been repeated at least 3 times per day to observe if there is improvement or deterioration."

105. I accept RN Johnson-Bogaerts' advice. RN E, RN B, and EN F did not use a pain assessment tool to assess Mr A. While RN C did attempt to use the Abbey Pain Scale on 26 Month1, the assessment was incomplete, and she did not use the tool subsequently. The staff also administered pain relief (Panadol) and, in my opinion, this warranted a pain assessment to gauge the effectiveness of the analgesia. As stated in Rowena Jackson's pain policy, a pain assessment tool should have been used by staff. I am also critical that given the repeated documentation of Mr A's pain, on 26 Month1 pain assessments and observations were not performed more regularly. In my opinion, this indicates a systemic issue by Rowena Jackson's staff to follow its own pain policy with particular regard to the care provided to Mr A on 25 to 27 Month1.

Escalation of care

26 Month1

106. According to Rowena Jackson, three faxes were sent to the GP. The first fax was sent by RN B on 26 Month1 with information regarding Mr A's behaviour and pain. The fax states that Mr A had been aggressive and non-cooperative and had refused medication. It refers to moderate/severe pain limiting his mobility, and asks the GP to chart PRN analgesia and "something for behaviour".

107. RN Johnson-Bogaerts stated that the request for pain medication and "something for behaviour" is concerning, and an indication that Mr A's symptoms were misunderstood. She stated:

> "In my opinion the symptoms warranted an urgent medical referral [seeing] [Mr A] was not very well known by the nurses — family indicated that difficulty mobilising was something new."

108. I accept RN Johnson-Bogaerts' advice and am critical that the initial fax requested only that medication be charted, and did not request a GP review.

109. Later that afternoon, Panadol was charted and administered but Mr A was still feeling pain in his left leg. RN C prepared a second fax, stating that Mr A appeared to be getting worse and had pain on movement. The fax included a set of observations and noted that the Panadol was not helping. RN C stated that she sent the fax and was then contacted by Dr D's office and told that he would come to review Mr A that afternoon. RN C said that it is likely that she spoke to either the receptionist or the nurse, as normally doctors do not call the rest home. However, in contrast, Dr D said that usually calls from Rowena Jackson Retirement Village would be put through to him, and he always documents calls with

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healthcare providers in the clinical notes. He cannot recall any conversation on 26 Month1, and he did not document a call.

110. A copy of the fax was provided to HDC, and I note that RN C recorded in the progress notes at the time that she faxed the GP requesting a review of Mr A. She also documented that she called Mrs A about seeking a GP review, and that Mrs A agreed to this. RN C said that the medical centre contacted her following her fax but she did not document her telephone call with the medical centre in the progress notes. Both Rowena Jackson and Dr D told HDC that because of the passage of time, the fax record is not available. Given the evidence available, I consider it more likely than not that RN C did send the second fax to the medical centre, but that it was not received by the medical centre. Owing to the lack of documentation and conflicting accounts, I am unable to make a finding on whether a telephone call between RN C and the medical centre occurred following the second fax.

111. As Dr D did not receive the fax and was not told about the request to review Mr A, he did not attend the rest home.

112. EN F stated that RN C told her that the GP would attend after he finished at the medical centre. EN F did not follow up, and said that by the time she realised that the GP had not arrived, it was too late to contact him.

113. Rowena Jackson told HDC that EN F, RN C, and RN B should have followed up with the GP on 26 Month1.

114. Rowena Jackson's "Accident and Emergency Services" policy states that if medical services beyond basic first aid are needed, the registered nurse or senior caregiver in charge is responsible for contacting a doctor and/or the ambulance service for transfer to the nearest general hospital with the appropriate facilities.

115. On the morning of 27 Month1, Mr A was grey and sweaty, and his foot was hot to touch. He had a slightly raised temperature and heart rate. RN C telephoned the GP's office and spoke to the nurse, who asked her to re-send the previous fax, which she did. The same copy of the fax sent on 26 Month1 was re-sent to the medical centre with no further detail added.

116. RN Johnson-Bogaerts is critical that the nurse on the afternoon shift of 26 Month1 did not follow up the urgent request for a GP review. RN Johnson-Bogaerts stated:

> "Symptoms warranted an immediate medical review. If the GP is unable to attend or is delayed nurses should feel empowered to refer their patient to hospital. If unsure if urgent hospital referral is warranted, it is accepted practice for a registered nurse to ask or phone a colleague or clinical manager for a second opinion any time of the day or night."

117. I agree with the advice from RN Johnson-Bogaerts that if the GP was unable to attend or was delayed, the nurses should have transferred Mr A to hospital in accordance with

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Rowena Jackson's Accident and Emergency Services policy. I am critical that Rowena Jackson's nursing staff did not arrange for Mr A to receive medical review immediately, given his lack of mobility, increased temperature, and left leg pain, and that no action was taken when the GP did not arrive to review Mr A during the afternoon of 26 Month1.

118. In relation to the care provided on 27 Month1, RN Johnson-Bogaerts stated:

> "I am concerned that on 27 [Month1] when the fax was resent to the GP practice the content was not updated with new information including the deterioration of [Mr A]. This would have enabled the GP to better assess the urgency of the request. All the faxes were marked 'urgent'."

119. I am critical that the third fax sent on 27 Month1 did not include any new detail about Mr A's deteriorating condition and, as a result, the GP discovered that Mr A had not been weight-bearing for two days only when he visited. Again, this demonstrates the failure of Rowena Jackson's staff to recognise Mr A's deteriorating condition and to adhere to the Accident and Emergency Services policy by considering transfer to hospital.

Conclusion

120. Although I accept that Rowena Jackson had in place appropriate policies, Rowena Jackson also had a responsibility for the actions of its staff, and to ensure compliance with the policies. A number of staff members failed to think critically about the monitoring and assessment of Mr A, and the appropriate escalation of his care when he reported pain. Mr A was cognitively impaired and no longer in a position to articulate his concerns clearly. As such, the onus for assessing Mr A and identifying the likely reason for his agitated state lay with Rowena Jackson. Its staff were responsible for managing his evolving symptoms and seeking medical attention in a timely manner, but this was not attended to adequately.

121. In summary, I find that Rowena Jackson did not provide appropriate care and services to Mr A following the discovery of his left leg pain on 25–27 Month1, for the following reasons:

a) Multiple staff failed to use an appropriate pain assessment tool and to monitor and assess Mr A's pain adequately on 25, 26, and 27 Month1.

b) There was a lack of urgency in obtaining a GP review, which should have occurred on 25 Month1.

c) Despite Mr A's deterioration, no referral or attempt to transfer Mr A to hospital was made following the delayed GP review on both 26 and 27 Month1.

d) Written communication with Mr A's GP was inadequate in that the initial fax sent did not contain all relevant information about Mr A's lack of mobility, and, when the second fax was re-sent, it was not updated to include new information about Mr A's deteriorating condition.

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122. As a consequence, Mr A's pain was not assessed and responded to appropriately, and resulted in a delay in the investigation and diagnosis of his fractured femur. Accordingly, I find that Rowena Jackson Village Limited failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Recommendations

123. In response to the recommendation in my provisional opinion, Rowena Jackson provided an apology to Mr A's family and also provided further information about the changes it has made since the events (as stated at paragraph 80 above).

124. I also recommend that Rowena Jackson Retirement Village Limited (trading as Rowena Jackson Retirement Village):

a) Audit its compliance with the falls management plan and prevention policies within the last three months, and report the results of the audit to HDC within three months of the date of this report. If 100% compliance is not achieved, Rowena Jackson is to advise HDC of the further actions that will be taken to ensure 100% compliance.

b) Audit the use of the amended fax referral document and compliance with the use of the new ISBAR fax template within the last month from the date of this report, and report the results of the audit to HDC within three months of the date of this report.

Follow-up actions

125. A copy of this report will be sent to the Coroner.

126. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Rowena Jackson Retirement Village Limited (trading as Rowena Jackson Retirement Village), will be sent to HealthCERT (Ministry of Health), the district health board, the New Zealand Aged Care Association, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Hilda Johnson-Bogaerts:

"1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided to [Mr A] at the dementia unit within Rowena Jackson Retirement Village. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Specifically I was asked to comment on the following:

   a. The adequacy of the assessments undertaken by the RNs, including whether the decisions made based on these assessments were appropriate.
   b. The adequacy of the nursing documentation.
   c. Whether the nursing staff provided the GP with appropriate information
   d. Whether the processes in place for requesting a GP review are adequate.

3. Review of clinical records and provider responses
[Mr A] was [in his seventies] when he was admitted to the secure dementia unit at Rowena Jackson Retirement Village on 21 [Month1]. His medical problems list included: Alzheimer Disease and Osteoarthritis. The nursing assessments of that time described him as at Medium Falls Risk. He was walking independently and had no history of falls. He needed minimal supervision with his morning cares; he was eating and drinking well those first few days in the care home.

On 25 [Month1] staff noted late at night that [Mr A] was agitated and very challenging. The registered nurse who assessed him that night reported that [Mr A] *'stated his left thigh is sore and cannot move'*. The nurse checked and did not see redness or bruises. No fall or other incident was reported. [Mr A] refused a heat pack for pain relief. The nurse was not able to give a painkiller because '*nil prn charted for pain*'. [Mr A] settled around 1.30am. The clinical notes state that a behaviour chart was commenced.

Seeing Osteoarthritis is on his medical problem list it could be assumed that this may have been the cause of his pain and upset. No objective pain assessment tool was used or pain observation chart commenced which would have been appropriate to monitor progress.

On the morning of 26 [Month1] it was noted early in the morning that [Mr A] refused his medication and was verbally abusive to the staff. The registered nurse assessed him and noted *'pain in his left groin and lower leg pain*', foot and ankle were oedematous, '*poor mobilising from chair — had to put him in wheelchair'*. A fax was sent to the GP *'for urgent meds — pain and prn behavioural'*. Pain relief was prescribed and administered at 11.04am with '*light effect but didn't last for long … can't mobilise*'. Observations were taken (temp. 37.6°C, O_2 94%, RR 22, HR 121, BP

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118/70). The next of kin was notified who said that the pain and reduced mobility was something new. Another fax was sent to the GP including the observations and requesting an *'urgent visit'*. However, by evening the GP had not visited. That evening [Mr A] stayed in his wheelchair all evening. He declined having his left leg elevated. He would express pain when they moved his leg and he was unable to weight bear but seemed settled in the lounge watching the cricket that night. He received assistance of two care staff when needing to toilet and when transferred to bed.

On 27 [Month1], [Mr A] was becoming increasing unwell. A follow up phone call was made to the GP practice — they had not received the second fax with the nurse's observations and request for an urgent review. The fax was re-sent at 10.30am and the GP confirmed that he would visit after work later in the day. [Mr A's] next of kin was also notified. The GP visited [Mr A] at 5.30pm and diagnosed him with a fractured neck of femur. The GP notes include that he observed external rotation of the left leg which is a tell tale sign for a fractured NOF. [Mr A] was then transferred to hospital via ambulance.

The letter dated 4 [Month3] from the GP to the coroner states that when the GP visited, [Mr A] was 'very unwell and in severe distress' in addition to the physical symptoms relating to his leg.

4. Clinical advice

a. The adequacy of the assessments undertaken by the RNs, including whether the decisions made based on these assessments were appropriate.

There was **no objective pain assessment tool** used to assess and document the severity of [Mr A's] pain which may have contributed to the underestimation of his pain. Assessing pain in older adults with dementia can be complicated because of the changes in the person's ability to communicate verbally. This presents a challenge to clinicians. There are however good objective tools that can be used. For example tools that measure breathing, negative vocalisation, facial expression, body language, and consolability.

The nurse's assessments included a rough description of the behaviour he presented. She reviewed the area where [Mr A] indicated he was in pain. It would have been appropriate to also assess limitations in movement or pain when moving. These **observations should have been repeated at least 3 times per day** to observe if there was improvement or deterioration.

The decisions made on 26 [Month1] to request that medication be prescribed for pain and 'something for behaviour' I find concerning and an indication that the symptoms were misunderstood. In my opinion the symptoms warranted an urgent medical referral because [Mr A] was not very well known by the nurses — family indicated that difficulty mobilising was something new.

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I am critical that the registered nurse on afternoon duty of 26 [Month1] did not follow up the urgent request for the GP to visit. Symptoms warranted an immediate medical review. If the GP is unable to attend or is delayed nurses should feel empowered to refer their patient to hospital. If unsure if urgent hospital referral is warranted, it is accepted practice for a registered nurse to ask or phone a colleague or clinical manager for a second opinion any time of the day or night.

[In view of] [Mr A's] deterioration on the morning of 27 [Month1] I am critical that the registered nurse did not increase the urgency for [Mr A's] medical review or forward a fax with an update on observations.

Together these issues would be seen by my peers as poor nursing practice.

Deviation from accepted practice — moderate to significant.

b. The adequacy of the nursing documentation
On 25 [Month1] when challenging behaviour was noted the registered nurse decided that a Behaviour Chart be commenced. I did not find such a behaviour chart included in the clinical notes — It is not clear if a chart was commenced or not. The intentional and regular documentation of behavioural symptoms would have provided a better picture over time of how symptoms evolved across the shifts. In addition and as mentioned above it would have been good practice for a pain assessment tool to have been used and for a pain observation chart to be commenced documenting systematically how his pain symptoms changed over time and across the shifts.

Deviation from accepted practice — minimal to moderate.

c. Whether the nursing staff provided the GP with appropriate information
The fax to the GP included a limited number of observations and background for the request. I am concerned that on 27 [Month1] when the fax was resent to the GP practice the content was not updated with new information including the deterioration of [Mr A]. This would have enabled the GP to better assess the urgency of the request. All the faxes were marked 'urgent'.

Deviation from accepted practice — minimal.

d. Whether the processes in place for requesting a GP review is adequate
The process of contacting the GP by way of a fax is accepted and good practice. The use of a blank fax however increases the variability between different nurses when completing the fax. This could be improved by way of a set document including a problem oriented format.

Deviation from accepted practice — minimal.

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General recommendation

- That a specific dementia pain observation chart be added to the care home's range of observation charts
- That the registered nurse attends a refresher on nursing assessments and clinical diagnosis with a Dementia focus
- That a nursing–medical order fax be created

5. Additional advice requested:
On 24 July 2019 I was asked to provide additional advice on the following:

a. The adequacy of [Mr A's] falls management plan when he was admitted to the secure dementia unit
[Mr A] had an initial/short version care plan in place which is accepted practice during the first weeks after a resident moves into a care home. He was assessed as 'medium falls risk' mostly due to his management plan/intervention '*to monitor and report any changes in his mobility to the registered nurse*'.

Seeing that he mobilised independently and had no history of falls this would be an appropriate management plan.

Deviation from accepted practice — nil.

b. The adequacy of the falls management plan and prevention policies in place at the retirement village at the time the care was received
The provided Falls Management Policy includes items to manage after one or more falls occurred however does not include items relating to ways to prevent falls before they occur.

Deviation from accepted practice — minimal to moderate.

c. The adequacy of the observations of [Mr A] in the days leading up to when he first started to appear unwell
The progress notes of the days after his moving in and leading up to when he first demonstrated agitated behaviour include well documented general observations of his behaviour, eating and drinking, cares provided at least twice a day. It is common for a person living with Dementia to be distressed and confused when moved to a different environment. Care staff and resident are still getting to know each other in these first days.

Deviation from accepted practice — nil.

6. Addendum: I was asked to review and comment in response to the additional information received from [Rowena Jackson] on 20 September 2019 when the provider responded to specific questions asked by HDC in a letter of notification dated 16 August 2019."

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Addendum to RN Johnson-Bogaerts's advice:

"**1. Adequacy of nursing assessment**

Under this question I raised in my original advice the concern about the lack of using an objective pain assessment tool appropriate to use with persons living with Dementia. Behavioural symptoms can be the result of underlying pain and other health issues.

The nurses' assessments did not include the use of a pain scale so that this could be repeated and reviewed. In addition the severity of the symptoms warranted a repeat at least every 3 hours to observe improvement or deterioration.

The provider showed that they have a good pain assessment tool and procedure. The nurses did not follow the procedure at this time. In addition I continue to be very concerned about the registered nurse asking the GP to prescribe 'something for behaviour'.

Overall I still think the adequacy of the assessments undertaken by the nurses was a moderate departure — They did not follow the organisation's procedure, did not repeat the assessments although indicated.

I changed the title on the memo from use of pain assessment tool back to adequacy of assessments to avoid the confusion that the reduction of the severity of departure might relate to the pain assessments only.

2. Yes my view on the documentation remains in terms of the documentation of pain — good practice would have required the documentation to include the clinical reasoning and follow up interventions.

3. Yes no changes.

4. Yes seeing the policies forwarded to us I will change this advice to nil deviation on the memo's addendum."

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