Rest Home
Clinical Services Manager, RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC01225)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man by a rest home and the Clinical Services Manager, during the man's residency. The report highlights the importance of ensuring that care plans and assessment accurately reflect the needs and support a resident requires. It also highlights the need for adequate monitoring and oversight of residents by nursing staff in a hospital-level care facility.

2. The man had complex care needs following a stroke, and required hospital-level care. During his residency, he had specialist input in relation to his nutrition and weight, but staff did not monitor this, and he lost weight. He required specific interventions for his braces, orthotics, and a sling, but there was a lack of support by staff with the interventions he required. In his final three months at the rest home, the man's overall health deteriorated, and his condition was not monitored adequately by nursing staff. In his final days at the facility, the man's advocate raised concerns to staff that his condition had deteriorated, and alerted staff to his actual condition. The advocate was responsible for contacting the public hospital and arranging for the man's subsequent admission.

Findings

3. The Deputy Commissioner found that the rest home breached Right 4(1) of the Code. In her view, the number of failings demonstrated an environment that did not support and assist staff sufficiently to do what was required of them.

4. The Deputy Commissioner also found the Clinical Services Manager in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that the Clinical Services Manager did not provide appropriate oversight of the nursing documentation and care planning, and did not communicate effectively with the GP, or ensure that the registered nurses for whom she was responsible monitored, assessed, and evaluated the man appropriately.

Recommendations

5. The Deputy Commissioner recommended that the Nursing Council of New Zealand carry out a competence review of the Clinical Services Manager, and that she apologise to the man and undertake training on clinical management, care planning and assessment, documentation, and complaints management.

6. The Deputy Commissioner recommended that the rest home provide training to its staff on clinical documentation, care planning, and assessment and monitoring of a deteriorating patient.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms A concerning the care provided to Mr B at the rest home. The following issues were identified for investigation:

- *Whether the rest home provided Mr B with an appropriate standard of care between October 2016 and March 2017.*
- *Whether RN C provided Mr B with an appropriate standard of care between October 2016 and March 2017.*

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

9. The parties directly involved in the investigation were:

Ms A	Consumer's welfare guardian
Mr B	Consumer
RN C	Provider/Clinical Manager
Rest home	Provider

10. Further information was also reviewed from:

Dr D	General practitioner
Dr E	General practitioner
District health board	

11. Independent expert advice was obtained from Registered Nurse (RN) Kate Lopez **(Appendix A)**.

Information gathered during investigation

12. Mr B (aged in his sixties at the time of these events) suffered an extensive left middle cerebral artery (MCA) infarction (a stroke)[1] in 2015, resulting in residual right-sided weakness, dysphagia,[2] aphasia,[3] and apraxia.[4] He also had a history of asthma and occlusion (obstruction) of his left retinal artery.

[1] An MCA stroke causes a language deficit, vision defects, and weakness and sensory deficit on the opposite side of the body.
[2] Difficulty swallowing.
[3] An impairment of language, affecting the production or comprehension of speech and the ability to read or write.
[4] Difficulty with the motor planning to perform tasks or movements when asked, despite the request or command being understood and the individual being willing to perform the task.

13. Following the stroke, Mr B was admitted to the DHB for rehabilitation, and later was transferred to a private hospital. In 2016, the Family Court appointed Ms A as Mr B's welfare guardian in relation to all aspects of his personal care and welfare.

Rest home

14. RN C was employed at the rest home as Clinical Manager from 2016 to 2018. She said that she was supposed to work under a Facility Manager, but the person appointed left after two days, so she was both the Clinical Manager and "de facto Facility Manager" until a new Facility Manager was appointed in 2016. She stated that after the Facility Manager left in 2017, she again had to cover both the Facility Manager and Clinical Manager roles until she was appointed as the Manager three months later.[5]

15. In response to the provisional opinion, RN C stated that this was her first role in an aged-care facility. She told HDC that she received no handover or orientation from the previous Clinical Manager, who had departed before RN C arrived. RN C said that during her first three months at the rest home she was overworked, isolated, and unsupported in her new role until a Facility Manager was appointed.

16. RN C's employment contract set out the expectations of the Clinical Manager's position under the heading "Clinical Management of Patients' care". A key task is to manage the clinical care of residents in a holistic manner. The performance indicators include:

- The care plans and patient files are up to date and indicate appropriate and safe clinical care of residents.
- There is evidence that patient care is monitored on a daily or shift basis and that recordings and daily notes are used by all staff to ascertain and action the requirements of care and any changes required.
- Complete nursing documentation is available showing current assessment, long and short-term care plans and interventions required, and including current accurate evaluations of patients' health status, using a nursing assessment and diagnosis process.
- There is evidence that patients receive expert nursing care from the Clinical Manager for such interventions as require such expertise.
- Patients and their families express satisfaction with the standard of care provided.

17. The Clinical Manager is required to ensure that staff are aware of, and use, the policies and procedures to guide them in their work. The Clinical Manager is also required to assist the Facility Manager in meeting the various standards and requirements for the ongoing licence/registration/contract for the facility, and in particular in meeting the clinical component of the Health and Disability Sector Standards required for certification. The employment contract also includes other tasks, such as formal oversight of all care processes, registered nurse training, and oversight of staff care and clinical skills.

[5] Clinical Manager and Facility Manager.

18. In response to the provisional opinion, RN C said that the Clinical Manager role involved working from 8.00am to 4.30pm, Monday to Friday, and her role included working two days as a registered nurse on the wards. RN C said that she did not work on weekends, but there were registered nurses on duty at all times. She stated: "Unless someone informed me, I did not know what was happening during the weekend." RN C also stated that the rest home did not have adequate policies and procedures in place at the time, and in late 2016 and early 2017 a new suite of policies and procedures were implemented by the Facility Manager.

19. At the relevant time, the former directors of the rest home told HDC that the Facility Manager and RN C were responsible for the day-to-day running of the rest home, and his involvement was governance of the company and oversight of improvements, such as the installation of a new kitchen. The former director stated that having sold the rest home in 2018, he no longer holds the relevant information about the facility requested by HDC.

20. HDC sought further information from the current owners of the rest home. RN C, in her capacity as one of the new owners[6] provided relevant clinical notes and health records. HDC sought further information from RN C in respect of relevant policies and care plans. RN C advised that during the time of transfer of the rest home, the previous owners removed documents from the premises, and she is unable to provide the information requested. In response to the provisional opinion, the former directors dispute that they removed any information from the facility. The former directors maintain that when they sold the rest home, the records relating to the business remained at the business.

Admission of Mr B to the rest home

21. On 20 October 2016, Mr B was admitted to the rest home for hospital-level care. The nursing care plan completed on 6 November 2016 states that Mr B had no pain. However, an InterRAI[7] assessment completed on 11 November 2016 describes him requiring gabapentin[8] and Panadol PRN (as required) for pain. The care plan was updated to reflect that Mr B required gabapentin and paracetamol for pain management. There is no evidence of any pain assessment or monitoring.

22. The assessment form states that Mr B is vegetarian, although Ms A stated that he is a vegan/vegetarian. The Director stated: "[W]e supplied [Mr B] with a vegan diet as he requested."

23. Mr B's care plan contained generalised information regarding his care, but did not contain specific information regarding use of his orthotics, braces, and hand splint.

24. On 20 October 2016, Mr B was reviewed by Dr D, who was Mr B's general practitioner (GP) prior to his admission to the rest home.

[6] Also a director.
[7] Resident Assessment Instrument — a standardised instrument for evaluation of the needs, strengths, and preferences of residents in long-term care.
[8] Gabapentin is used to treat neuropathic pain.

25. On 25 October 2016, RN C referred Mr B to a speech language therapist (SLT) for assessment of his speech and swallowing reflex.

26. On 29 October 2016, Ms A asked staff to monitor Mr B's fluid intake and urine output. The rest home commenced a fluid balance chart.

27. On admission, Mr B's weight was recorded as 57.6kg. On 31 October 2016, the records state that Mr B was to be weighed fortnightly. A dietitian assessed him, and instructed that he have a soft diet and mildly thickened fluids. Ms A expressed concerns to RN C that Mr B had been given rice and bread, which he was unable to eat. His long-term care plan goal stated that he was to have a balanced diet and adequate fluid intake, but did not identify a planned weight range.

28. On 2 November 2016, Ms A asked staff to make sure that Mr B received Ensure[9] five times a day. Fluid balance charts continued to be completed, and included details of the fluids and food provided, but generally did not record Mr B's urine output. The facility's GPs, Dr D and Dr E, told HDC that there was never any suggestion that Mr B was not drinking enough, and that it would have been apparent clinically if he had become dehydrated. They stated: "We ourselves never asked about his urine output, and if it had been raised with us, we would have instructed the nurses there was no value in doing this (recording the urine output)."

29. On 11 November 2016, the progress notes state that Mr B was not well, and was administered oxygen at 2L/minute, and that subsequently his oxygen saturations[10] increased to 95%. RN C recorded that Mr B was not short of breath.

30. On 18 November 2016, Mr B was seen by a physiotherapist, who noted that Mr B needed to continue to wear a shoulder support and hand splint, and an ankle foot orthotic when mobilising. She noted that Mr B was quite short of breath due to asthma. RN C told HDC that following the visit by the physiotherapist, she instructed the nurses to develop specific and individual nursing care plans.

31. Between 18 and 22 November 2016, it was recorded in the clinical notes that Mr B had earache in his right ear. On 23 November 2016, the nursing notes state that the doctor was informed that Mr B had pain on the right side of his ear, and the doctor charted the antibiotic Augmentin, and codeine as required for pain relief.

32. On 30 November 2016, Mr B was seen by a speech language therapist. Ms A was present for the assessment. During the assessment, Mr B was able to consume thin fluids and soft food with no signs of aspiration.

33. On 2 December 2016, Mr B's weight was 55.75kg, and it is recorded in the nursing notes that he was continuing to lose weight, despite having Ensure five times a day and eating

[9] Ensure is the brand name of a nutritional supplement/meal replacement drink.
[10] A measurement of blood oxygen. A normal reading is typically 95–100%.

small amounts. It is noted that the dietitian was to visit on 8 December 2016, and that Ms A would attend the appointment.

34. On 8 December 2016 at around 9.10am, Mr B collapsed in the corridor. The nursing notes state that his body was stiff and shaking. He was assisted to sit on a wheelchair. RN C took his vital signs and then called Dr D. The doctors' notes record that Dr D attended, and that at that time Mr B's observations were normal. The plan was to "Observe".

35. That day, the dietitian saw Mr B because he had lost 2kg over the previous two months. At that time, his weight was 55.6kg. The dietitian recommended weighing Mr B weekly. However, he was weighed only a further eight times during the 12 weeks between 19 December 2016 and his transfer to hospital on 19 March 2017.

36. On 23 December 2016, the speech language therapist visited Mr B to conduct a further assessment of his language. Ms A was present. Mr B was discharged from the SLT service, as it was felt that there was no further benefit from SLT input at that time.

37. Between 26 and 28 December 2016, the nursing notes record Mr B removing his splints or refusing to wear them.

38. Mr B continued to have a poor oral intake and to eat minimal food. On 10 February 2017, the dietitian undertook a nutritional assessment and noted that Mr B's weight had dropped to 51.9kg, which was a further reduction of 3.6kg.

39. In response to the provisional opinion, RN C told HDC that Ms A advised her that Mr B had "never been a good eater".

Deterioration

40. On 12 March 2017, the nursing notes state that Mr B had rung the bell because he was coughing and had a sore throat. A nurse undertook observations and found that his temperature was 36.3°C.[11] On 13 March 2017, his temperature was 38°C.[12] He was administered Panadol and his temperature reduced to 36.1°C. On 13 March 2017, the nursing notes state that he was still not feeling well. At 10pm on 14 March 2017, his temperature was 38.3°C,[13] so he was again administered Panadol. There is no further entry by a nurse until 19 March 2017.

41. RN C said that Wednesday 15 March 2017 was a doctors' round day. She stated that she had checked Mr B's observations that day and he was afebrile (no fever). She said that she informed Dr E about Mr B's cough, and that he had had two episodes of raised temperature since the previous Sunday and was generally unwell.

42. Dr E said that on 15 March 2017 he was asked to assess Mr B for itchy ears, and at that stage Mr B was alert, afebrile, and well hydrated. Dr E stated that Mr B did not cough

[11] Within normal range.
[12] Mild fever.
[13] Mild fever.

during the assessment. Dr E diagnosed mild bilateral otitis media[14] and prescribed ear drops. He said that he asked Mr B whether there was anything else wrong, and Mr B shook his head. Dr E recorded that Mr B was "troubled by noise", "blood from chin", and "itch[y] ears", but there is no reference to Mr B's condition during the previous days.

43. On 18 March 2017, the nursing notes state that Mr B had a poor appetite, was coughing continuously, and stayed in his room all morning.

44. Ms A stated that Mr B's friend contacted her and offered to take him to her home to give him a break from the rest home. Ms A told HDC:

> "What was making it more intolerable for [Mr B] was the refurbishment of the hallway and adjacent rooms to his; so workmen coming and going throughout the day, noise, paint fumes, etc."

45. Ms A stated that she told the rest home that Mr B would go to his friend's house for a break. Ms A arranged to meet the friend at the rest home on 19 March 2017 after 11am. Ms A stated that when she arrived and saw Mr B, she was quite concerned because he looked terrible, was short of breath, had green snot, and was coughing green phlegm. She said that she emptied Mr B's urine bottle and it smelt and looked bad, so she asked the nurse to check Mr B's temperature.

46. A nurse recorded in the progress notes at 12.30pm that she had checked Mr B's temperature and it was 38.6°C. Ms A stated that Mr B was tachycardic[15] with a heart rate of 126 beats per minute (bpm) and was tachypnoeic[16] with a respiration rate of 28–30 breaths per minute. His oxygen saturations were 86%.

47. Ms A stated that when the nurse looked back through Mr B's observation charts and notes it was evident that he had had a fever for three days. Ms A requested that Mr B be seen by a doctor, and the nurse contacted RN C, who attended. RN C said that the nurse told her that she had messaged Dr D.

48. Dr D stated that neither he nor Dr E "took a call" that day, and it appears that the nurses did not persist because it had been decided to take Mr B to hospital. Dr D said that the nurses would have been able to contact the doctors had they persisted.

49. Ms A said that she expressed her concerns regarding the lack of care Mr B had received. She contacted the on-call medical registrar at the public hospital, and then drove Mr B to hospital.

Public hospital

50. At 2.38pm on 19 March 2017, Mr B was admitted under the general medical team. He was diagnosed with right lower lobe pneumonia and received three days of intravenous (IV)

[14] Inflammatory disease of the ear.
[15] A heart rate that exceeds the normal resting rate.
[16] Excessively rapid respiration.

antibiotics and was then changed to oral antibiotics to complete the course. He received physiotherapy and SLT input during the admission.

51. Mr B was discharged on 25 March 2017. Ms A told HDC that while Mr B was in hospital, his friend offered to look after him, so he was discharged back to her home.

Communication with Mr B's welfare guardian

52. RN C stated that Ms A's complaint to HDC was because the staff at the rest home refused Ms A's request that staff administer medical marijuana to Mr B. RN C said that Ms A's request presented an ethical dilemma to the nursing staff. RN C also said that she suspected that Ms A had obtained an illegal substance and was involved in an illegal activity. In response to the provisional opinion, RN C acknowledged that her comments about Ms A and the use of medical marijuana were inappropriate and unprofessional. RN C also told HDC that the Director made the decision in response to Ms A's request for medical marijuana.

53. There is no reference to Ms A's request for medical marijuana in the clinical notes provided, or in any response from rest home staff in relation to this investigation.

54. In response to the "information gathered" section of the provisional opinion, Ms A stated that she had a discussion with RN C, and then Dr D, about obtaining medical marijuana, but they could not assist with the request. Ms A said that she accepted RN C's and Dr D's decisions, and there was no further discussion about obtaining medical marijuana for Mr B.

Policies and documentation

55. HDC requested that the rest home supply its policies regarding:

1. Admission procedures, including completion of initial assessment and care plans.
2. Completion of nursing care plans, including short-term care plans.
3. Advance Directives, Advance Care Plans, or Medical Care Guidance Plans.
4. Recognition and response to residents' clinical deterioration.
5. Direction and delegation between registered nurses and caregivers.
6. Documentation.
7. Assessment and management of pain and any relevant documentation, including a pain assessment form or similar.
8. Nutrition and hydration, including any relevant guidance on completion of fluid balance charts, and any relevant documentation such as food diary documents or similar.
9. Access to specialists such as a dietitian, physiotherapist, speech language therapist, community stroke rehabilitation service, or similar.
10. Communication with family/next of kin, including how this should be documented in the clinical file.
11. Communication with GPs.

56. In addition, HDC requested that the rest home provide the following information regarding Mr B:

1. Short-term care plans completed during the admission.
2. Pain assessment forms completed during the admission.
3. Physiotherapy assessment and plan.
4. Documentation that records communication with the GP for that period, eg, relevant faxes to the GP, a GP list describing residents who needed to be reviewed during a round and why.
5. Documentation that records communication with family/next of kin/EPOA.

57. The rest home did not provide the requested policies and information. The former director said that the rest home had been sold, and that all clinical and operating information was handed over to the new owners upon settlement. HDC requested policies and information from the new owners of the rest home, but this was not provided to HDC. The new owners said that the former owners removed documents from the premises at the time of transfer of the business. The former directors dispute this assertion.

Responses to provisional opinion

58. Ms A, RN C, the former directors of the rest home, and the new owners were all given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, their comments have been incorporated into the report.

59. Ms A told HDC that often she purchased extra food for Mr B because the rest home was not able to provide food that was appropriate or appealing. She said that she had discussions with staff about Mr B's food preferences, but felt that staff thought he was fussy.

60. RN C told HDC that she is "deeply saddened that her long term care relationship with [Mr B] ended the way it did". She said that with the benefit of time and reflection she has reviewed the circumstances giving rise to this complaint, and she accepts responsibility for some of the aspects of the deficiencies in Mr B's care.

61. RN C submitted that she was hampered in her ability to undertake her responsibilities as the Clinical Services Manager owing to her inexperience, the departure of the Facility Manager, and the inadequacy of the policies and procedures in place at the time of events. RN C accepted the provisional decision in relation to the standard of documentation after December 2016, and the clinical care provided, as this relates to the inadequate documentation.

62. RN C submitted that she has undertaken ongoing training in relation to clinical leadership, dementia, and monitoring a deteriorating patient. RN C stated that in 2018 she attended a conference on InterRAI assessment, quality, governance, and complaints management, and also attended a course on auditing, quality improvement, technology, and the responsibilities of registered nurses in aged care. She has also personally undertaken ongoing training with a focus on aged care.

63. RN C told HDC that in her role as the Clinical Manager and currently as Facility Manager at the rest home, she has implemented a new suite of policies and procedures that include requirements around the use of short-term care plans, interRAI assessments, clinical documentation, and staff training. RN C considers that these changes have addressed a number of the criticisms outlined in the provisional opinion.

Relevant standards

64. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> 4.7 Deliver care based on best available evidence and best practice.
>
> 4.8 Keep clear and accurate records.
>
> 4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines.
>
> 4.10 Practise in accordance with professional standards relating to safety and quality health care.
>
> …
>
> 7.0 Act with integrity to justify health consumers' trust.
>
> …
>
> 7.2 Protect vulnerable health consumers from exploitation and harm.
>
> …
>
> 8.1 Maintain a high standard of professional and personal behaviour."

65. The New Zealand Health and Disability Services (General) Standard (NZHDSS) 1994 states:

> "NZS 8134.1.2.2 Organisational management
>
> Service Management
>
> The organisation ensures the 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."

Opinion: Rest home — breach

Introduction

66. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), the rest home had a responsibility to operate the facility in a manner that provided its residents with services of an appropriate standard. The NZHDSS[17] also requires that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers.

67. Although the rest home employed a Clinical Manager and a Facility Manager during Mr B's residency at the rest home, the position of the Facility Manager was vacant for a period of time. In these circumstances, it was not sufficient for the rest home to further abrogate its responsibility for the operation of the facility. The rest home remained responsible for the services provided in its facility. Mr B was assessed as requiring hospital-level care and, owing to the complexity of his needs, he required a nurse to oversee his care on a 24-hour basis. This case highlights the importance of aged residential care facilities having staff with adequate expertise and skill to support residents with chronic medical conditions and complex co-morbidities. In such circumstances, medical, nursing, and support staff need to be alert to a resident's changing health status. Staff must assess, think critically about, and respond appropriately to, deterioration in the resident's condition. In my view, the rest home failed in its duty of care to provide an appropriate standard of care to Mr B.

Policies

68. The rest home was required to supply HDC with relevant policies and documentation. It did not provide the requested information, and the reason it gave was that it had sold the facility in 2018 and transferred the documentation on settlement.

69. In my view, this response was unsatisfactory. It was the responsibility of the rest home either to retain copies of the relevant health records or, if the records had been transferred to another provider, to take reasonable steps to obtain the information requested. I am highly critical that the rest home did not provide HDC with the required information relating to Mr B's care.

70. HDC obtained Mr B's clinical notes and health records from RN C, one of the current owners of the rest home. However, RN C did not provide the further information requested, and said that the former rest home owner removed documents from the premises at the time of transfer of the business.

Admission and care planning

71. Mr B was admitted to the rest home on 20 October 2016. Mr B had complex health needs due to a stroke in 2015, resulting in residual right-sided weakness, dysphagia, aphasia, and apraxia. He also had a history of asthma and occlusion (obstruction) of his left retinal

[17] The New Zealand Health and Disability Services Standards are mandatory for relevant service-based contracts that receive health funding, including hospitals, rest homes, and some providers of residential disability care.

artery. Mr B was assessed for hospital-level care owing to his high needs. His initial assessment and care plan were undertaken on admission. However, it was a further 17 days until the care plan was completed on 6 November 2016. The care plan noted that Mr B had no pain. However, an InterRAI assessment completed on 11 November 2016 describes him requiring gabapentin and Panadol for pain as needed. Despite this, there is no evidence of any pain assessment or monitoring.

72. Progress notes were recorded on at least a daily basis during Mr B's residency at the rest home. However, there were multiple inconsistences between the clinical progress notes and the care plans and assessments completed. On admission, Ms A gave the rest home pertinent advice about appropriate interventions for Mr B's need for braces, orthotics, and a sling, but the information was not documented in the initial assessment and care plan, and the foot splint is mentioned only in the care plan completed on 6 November 2016. Furthermore, although the physiotherapist gave advice, and the instructions are reflected in the progress notes, they are not reflected in the nursing care plan.

73. The care plan was not reviewed following the dietitian review on 8 December 2016, at which a 2kg weight loss was noted, and no short-term care plan was prepared. Mr B was reviewed again by the dietitian on 10 February 2017, and by that stage he had lost 3.6kg, but his requirements were not communicated in a short-term care plan.

74. I consider that Mr B's care plan was inadequate, and that neither the initial assessment and care plan completed on 20 October 2016, nor the nursing care plan completed on 6 November 2016 is consistent with Mr B's assessed needs as described in the progress notes. There is no evaluation or review of the care plan, and no short-term care plans were provided. As stated, a request was made to the new owners of the rest home for documentation, including short-term care plans, but these were not provided. Accordingly, I find that no short-term care plans were completed in response to acute problems or short-term needs.

75. My expert nursing advisor, RN Kate Lopez, advised that Mr B's nursing care needs were complex, and it was critical that his needs were communicated clearly to all staff through the nursing care plan, and that the care plan was evaluated and updated when his needs changed. RN Lopez stated: "It is also critical that a resident assessed as requiring hospital level care, has that care overseen by an RN at all times."

76. RN Lopez stated that it was of concern that Ms A needed to be involved in informing staff about Mr B's care needs, because of the staff's lack of apparent awareness of the interventions required. RN Lopez considered this to be a departure from the expected standards, which her peers would view with moderate disapproval. RN Lopez noted that in October and November 2016, key interventions to support Mr B were documented in the progress notes rather than in a nursing care plan. She stated that capturing such information in the progress notes does not negate the requirement for a thorough and up-to-date care plan. RN Lopez said:

> "RNs and HCAs [healthcare assistants] cannot be expected to read back through weeks and months of progress notes to find key information to guide their care on a

shift by shift basis. Therefore, key information about caring for [Mr B] and the context of his complex needs was not accessible to staff and this represents a significant risk."

77. I agree. Mr B had complex care needs and was admitted to the rest home for hospital-level care, and his support requirements were likely to be extensive. The care plan did not reflect the support Mr B required in relation to his residual right-sided weakness, dysphasia, aphasia and apraxia, or his history of asthma and obstruction of his left retinal artery. I am highly critical of the omissions in Mr B's care plans and assessments, and that these did not adequately reflect his complex needs and the extensive support he required. This information was critical to guide the nurses and caregivers in their care of Mr B in the context of his complex health needs. In my view, this poor communication between staff placed Mr B's well-being at risk, as staff were not aware of his current care needs and the interventions he required.

Nursing oversight

78. The clinical records indicate that a registered nurse oversaw Mr B's care following his admission in October 2016. However, between December 2016 and Mr B's transfer to hospital on 15 March 2017, there are only five entries by a registered nurse in the clinical notes. During that period, Mr B's health declined, and he had significant weight loss.

79. RN Lopez is highly critical of the lack of nursing oversight from December 2016, and noted that during this time Mr B's health condition declined. She stated: "This is highly inappropriate given the complexity of [Mr B's] needs." She said that Mr B's care provision in light of his previous stroke departed from the standards expected, and that her peers would view this with severe disapproval. RN Lopez also said that hospital-level care services are required by the Age Related Residential Services Agreement[18] to provide at least one registered nurse on duty at all times.

80. Mr B was assessed as requiring hospital-level care owing to the complexity of his condition and the need for a nurse to oversee his care on a 24-hour basis. It is highly concerning that on the evidence available to me it is unclear what level of nursing oversight was provided to Mr B during his final three months of residency at the rest home. Mr B's health deteriorated during this time, and the level of supervision by registered nurses was not adequate to meet his needs. While RN C has some responsibility in this respect, overall I consider that it was the rest home's responsibility to ensure that Mr B was provided with adequate nursing care. It is highly likely that further intervention by specialist experts was also warranted over this time, including the GP, hospital services, and allied health services.

Weight loss

81. Mr B had known dysphagia and poor oral intake. SLT and dietitian input were obtained. However, the recommendations made are not reflected in the care plan. On 8 December 2016, the dietitian recommended weighing Mr B weekly. However, he was weighed only a

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

further eight times in the 12 weeks between 19 December 2016 and his transfer to hospital on 19 March 2017.

82. RN Lopez advised that the care plan should have stated Mr B's needs and preferences clearly. She also noted that the fluid balance charts were used to record both food and fluid intake, which is not usual practice.

83. RN Lopez said that although the healthcare assistants recorded Mr B's intake, there was no nursing oversight in response to his oral intake and weight loss, and no change in his plan of care. RN Lopez stated:

> "Ensuring [Mr B's] nutritional needs were met was a key component in maintaining his physical health. However, individuals' relationship with food is also an important aspect of cultural and psychosocial well-being."

84. RN Lopez said that the rest home's lack of support for Mr B's oral intake and response to his subsequent weight loss were a departure from expected standards that her peers would view with moderate to severe disapproval.

85. I agree. Mr B's nutritional needs were a critical aspect of his overall health. It was noted on admission that Mr B had poor oral intake and nutrition, and specialist advice was sought. However, staff failed to respond to the specialist advice appropriately and ensure that it was communicated to all staff adequately in Mr B's care plan. Further, staff failed to follow the specialist advice and monitor Mr B's weight. Overall, this shows a lack of attention to, and recognition of, Mr B's needs by multiple staff.

Deterioration

86. From 12 to 14 March 2017, the records describe Mr B as being unwell and having a cough, lethargy, and reduced appetite. However, there is no further record by a registered nurse until 19 March 2017 (a Sunday), when Ms A informed a nurse that Mr B had dark-coloured and foul-smelling urine. The nurse contacted RN C, who was not on duty, and she came to the facility. No vital signs are recorded on Mr B's observation chart between 15 and 19 March 2017.

87. RN Lopez advised that it is apparent that Mr B's condition had been deteriorating for seven days prior to his acute admission to hospital on 19 March 2017. However, there is insufficient evidence in the clinical documentation that he received the appropriate level of oversight and assessment from a registered nurse during that time. There is no evidence to suggest that a short-term care plan was produced.

88. On 15 March 2017, Mr B was reviewed by Dr E, who told HDC that the review was related to itchy ears. Dr E focused his assessment on Mr B's ears, and made no reference to Mr B's condition during the previous days. In contrast, RN C stated that she told Dr E about Mr B's condition over the previous few days, but there are no contemporaneous records of this discussion.

89. It is unclear what information was conveyed to Dr E, owing to differing recollections and a lack of contemporaneous documentation. Rest home staff knew that from 12 March 2017 Mr B's condition had deteriorated, and this was pertinent information to convey to a GP prior to a review. It appears that this information was not communicated to Dr E adequately when he was asked to review Mr B on 15 March 2017. I am critical of the standard of communication with the GP on this occasion.

90. It is concerning that on the morning of 19 March 2017, Mr B's deterioration was first observed by Ms A rather than rest home staff. RN Lopez advised that there was a lack of appropriate assessment, critical thinking, and action in response to Mr B's deteriorating condition. She stated that her peers would consider this to be a moderate to severe departure from the accepted standard.

91. I accept this advice. I am highly critical that there was insufficient clinical oversight, assessment, and monitoring of Mr B's condition by a registered nurse when staff were alerted to his deteriorating condition. Documentation is a key function of nursing care, and in my view the lack of documentation contributed to the failure of staff to recognise Mr B's actual condition and to communicate this to the GP adequately and provide appropriate interventions.

Conclusion

92. Although this Office has been provided with limited information about the rest home's policies and procedures, the failure of staff to provide Mr B with an appropriate standard of care points towards an environment that did not support and assist staff sufficiently to do what was required of them. I am concerned that aspects of the care provided was suboptimal. In particular:

- The nursing care plans and assessments were inadequate and omitted pertinent aspects of Mr B's care and key interventions, including specialist input.
- Between December 2016 and Mr B's transfer to hospital on 19 March 2017, the clinical notes contain only five entries by a registered nurse. There is no documentation of any review of Mr B by a registered nurse between 15 and 18 March 2017. It is therefore unclear what level of nursing oversight was provided to Mr B during his final three months of residency at the rest home.
- Staff failed to follow specialist advice about Mr B's nutritional needs and to monitor his weight regularly.
- On 12 March 2017, staff were alerted to Mr B's deteriorating condition but failed to provide sufficient clinical oversight, assessment, and monitoring of his condition.

93. In my view, the rest home had the ultimate responsibility to ensure that Mr B received care that was of an appropriate standard and complied with the Code. In addition, it was responsible for ensuring that it had the clinical expertise necessary to support residents with complex health issues. For the reasons outlined above, I find that the rest home failed in that responsibility and breached Right 4(1) of the Code.

Opinion: RN C — breach

Introduction

94. RN C's Clinical Manager position description states that she was responsible for the following:

> "Complete nursing documentation is available showing current assessment, long and short term care plans and interventions required, and including current accurate evaluations of patients' health status, using a nursing assessment and diagnosis process.
>
> There is evidence that patients receive expert nursing care from the Clinical Manager for such interventions as require such expertise."

95. RN C was employed at the rest home as Clinical Manager at the time of these events. I note that in response to the provisional opinion, she has accepted that she was liable for the clinical nursing issues that arose. However, she submitted that her ability to perform the tasks as the Clinical Manager was hampered by a lack of experience, absence of support from a Facility Manager, and inadequate policies and procedures at the time of events.

96. Mr B was admitted to the rest home on 20 October 2016 requiring hospital-level care. He had high needs with right-sided weakness, and swallowing, speech, and movement difficulties. He also had a history of weight loss. This section of the opinion considers the care RN C provided to him from 20 October 2016 until his admission to the public hospital on 19 March 2017.

Oversight of clinical documentation

97. I note that in response to my provisional opinion, RN C accepted that staff failed to record the care provided to Mr B adequately, in particular in relation to short-term care plans and clinical notes. RN C also accepted that there were deficiencies in her documentation of the care that she provided to Mr B.

98. RN Lopez noted that neither Mr B's initial assessment and care plan completed on 20 October 2016, nor the care plan completed on 6 November 2016 were consistent with Mr B's assessed needs as described in the progress notes. RN Lopez also noted that there was no evaluation or review of the care plan, and no short-term care plans were completed in response to Mr B's acute problems.

99. Mr B was reviewed by a physiotherapist, a speech language therapist, and a dietitian, owing to his complex health needs following a stroke. The specialist assessments and recommendations were recorded in the progress notes, but not in Mr B's nursing care plans.

100. RN C advised HDC that Mr B had a vegan diet, but it was recorded in Mr B's care plan that he was a vegetarian. RN C noted that Ms A described Mr B as having "never been a good eater in his life. He was 40 odd kg before his stroke." The clinical records indicate that from December 2016 until his transfer to hospital on 19 March 2017, a registered nurse

reviewed Mr B on five occasions. During that period, Mr B's health declined and he had significant weight loss of 5.7kg.

101. RN Lopez advised that Mr B's nursing care needs were complex, and it was critical that those needs were communicated to all staff clearly through the nursing care plan, and that the care plan was evaluated and updated when his needs changed. RN Lopez stated:

> "I am highly critical of the adequacy of clinical documentation, and in particular the degree to which the documentation provides evidence of an appropriate level of RN oversight given [Mr B's] condition and level of care required."

102. I accept this advice. Mr B's nutritional intake and his splints were important for his overall well-being. As the Clinical Manager it was RN C's responsibility to monitor the documentation of nursing care plans, review assessments, and ensure that documentation was adequate. I accept RN C's submission that factors hampered her ability to perform her role as the Clinical Manager. However, I do not consider that these factors absolve her of the Clinical Manager responsibilities. I also note that RN C accepts that there were deficiencies in her documentation and oversight of the documentation by staff of the care provided to Mr B. In my view, RN C's lack of oversight of the nursing documentation placed all aspects of Mr B's well-being at risk and contributed to the poor communication between staff about Mr B's holistic care needs.

Clinical care

103. On 12 March 2017, staff recorded that Mr B reported that he felt unwell, and over the following days they recorded that he had a cough, general lethargy, and a poor appetite. RN C told HDC that she monitored Mr B closely following Dr E's review on 15 March 2017, but this is not recorded in the progress notes. From 16 to 18 March 2017 there is no record of a nursing review of Mr B's condition.

104. I have received conflicting evidence as to whether on 15 March 2017 Dr E was advised of Mr B's condition over the previous few days. Dr E stated that he was asked to review Mr B because he had itchy ears, and the clinical records support this statement. Dr E focused his assessment on Mr B's ears, and made no reference to Mr B's condition during the previous days. In contrast, RN C asserts that she informed Dr E about Mr B's history, but there is no contemporaneous documentation of this discussion.

105. Mr B's recent clinical deterioration was pertinent information to hand over to a GP for an assessment of his condition. I also note that given Mr B's inability to speak for himself, RN C had the responsibility to advocate on his behalf. Although it is unclear what information was conveyed to Dr E, owing to differing recollections and a lack of contemporaneous documentation, it appears that Mr B's deteriorating condition was not communicated to Dr E adequately. In my view, it was RN C's responsibility to ensure that pertinent information was communicated to Dr E, and given the lack of documentation I consider it more likely than not that this did not occur.

106. RN Lopez noted that nursing oversight of hospital-level residents is required under the NZHDSS and the ARRC[19] contract, as well as being a professional obligation of a registered nurse. RN Lopez advised that although RN C stated that she monitored Mr B closely on 16 and 17 March 2017, this was not recorded in the clinical notes. RN Lopez said that there is no evidence of sufficient assessment, monitoring, and evaluation of Mr B's condition by a registered nurse on 16 and 17 March 2017. In addition, there is no evidence of any short-term care plans to direct staff on the specific interventions for Mr B, in light of his deteriorating condition.

107. As the Clinical Manager, RN C was required to provide expert nursing care and interventions to the residents at the rest home. I am highly critical of RN C's assessment, monitoring, and the lack of documentation of the care she provided to Mr B in his final days of residency at the rest home. In light of his deteriorating condition, RN C should have provided guidance to staff on their care of Mr B.

Response to Mr B's advocate

108. RN C told HDC that a request by Ms A (Mr B's welfare guardian) to administer medical marijuana to Mr B presented an ethical dilemma to the nursing staff. RN C also stated that she suspected that Ms A had obtained an illegal substance and was involved in an illegal activity. However, there is no reference to Ms A's request for medical marijuana in the clinical notes provided, or in any response from rest home staff in relation to this request.

109. RN Lopez said that the Nursing Council Code of Conduct[20] requires that nurses "[a]ct with integrity to justify health consumers' trust" and "[p]rotect vulnerable health consumers from exploitation and harm".[21] In addition, it requires that nurses "[k]eep clear and accurate records"[22] and "[m]aintain a high standard of professional and personal behaviour".

110. RN Lopez advised that any request by Ms A or friends of Mr B for the use of medical marijuana to be prescribed should have been documented and appropriate action taken. RN Lopez said that RN C's comments and response to this complaint were "unprofessional".

111. I agree. The clinical notes provided do not support RN C's statement about Ms A's request that staff administer Mr B medical marijuana. I am critical that RN C failed to maintain accurate records to guide the actions taken by the rest home and its staff. I note that [the rest home] policy on communication was requested, but not provided. Nonetheless, in these circumstances, accurate recording of communication with family was essential to guide rest home staff on its further actions. I note RN C's comments about Ms A during the course of this investigation, and am highly critical that they show a lack of professionalism and support to Ms A as the welfare guardian of Mr B.

[21] Age-related residential care.
[20] Principal 8.1. http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct.
[21] Principal 7.2. http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct.
[22] Principal 4.8. http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct.

Conclusion

112. As the Clinical Nurse Manager, RN C was responsible for providing clinical leadership of other staff, and effective nursing care. RN C did not ensure that appropriate documentation and care planning were completed for Mr B, did not communicate effectively with Dr E, and did not ensure that the registered nurses for whom she was responsible monitored, assessed, and evaluated Mr B appropriately. Accordingly, RN C failed to provide services to Mr B with reasonable care and skill in relation to clinical documentation and clinical care, and I find that RN C breached Right 4(1) of the Code.

Recommendations

113. I recommend that RN C provide a written apology to Mr B for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr B.

114. I recommend that the Nursing Council of New Zealand consider undertaking a competence review of RN C.

115. I recommend that within three months of the date of this report, RN C provide evidence to HDC of having undertaken relevant training on clinical management, care planning and assessment, documentation, and complaints management.

116. I recommend that within six months of the date of this report, the new owners of the rest home provide training to relevant staff on the following issues, and provide evidence of the training to HDC:

a) Clinical documentation
b) Care planning
c) Assessment
d) Monitoring of a deteriorating patient.

Follow-up actions

117. A copy of this report with details identifying parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, which has been advised of RN C's name.

118. A copy of this report with details identifying the parties removed, except the expert who advised on this case will be sent to the Ministry of Health (HealthCERT), the DHB, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Expert advice to the Commissioner

The following expert advice was obtained from RN Kate Lopez:

"I have been asked to provide an opinion to the Commissioner on case number 17HDC01225. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a Registered Nurse, and hold a Post Graduate Diploma in Health Sciences, endorsed in Nursing, and a Masters of Business Administration. I have worked in inpatient hospital and community services as a Registered Nurse, including as a Facility Manager in Aged Residential Care, before commencing as Nursing Director for Older People (Population Health) for the Canterbury and West Coast District Health Boards from 2012–2018. My experience in aged residential care relates to working within the sector as Registered Nurse, Clinical Coordinator/Assistant Manager, and then as Facility Manager; and then in my role as Nursing Director, a nursing leadership role providing a professional nursing opinion to the DHB and from time to time the MOH with regard to service reviews, complaint investigation and response, service improvement initiatives, system wide quality improvement activities, and provision of strategic and professional nursing leadership for the sector. Since early 2018 I am now engaged as a Consultant to provide expert advice and consultancy with regard to health system performance, predominantly with the Health Roundtable in support of NZ DHBs as the Relationship Manager for NZ.

To the best of my knowledge I have no personal or professional conflict of interest in providing this advice.

Expert advice requested

I have been asked to provide my opinion on the care provided by [the rest home] to [Mr B] between October 2016 and March 2017 (inclusive). I have been asked to review the documentation provided, and advise whether I consider the care provided to [Mr B] at [the rest home] was reasonable in the circumstances, and why.

In particular, I have been asked to comment on:

1. The adequacy of the care provided to [Mr B] in the days immediately prior to his hospitalisation
2. Whether there was appropriate escalation of concerns regarding [Mr B's] condition
3. The adequacy of the clinical documentation
4. The adequacy of the services provided to [Mr B] in light of his previous stroke
5. [Mr B's] oral intake and weight loss
6. The appropriateness of requesting clinical input from [Ms A] about [Mr B's] care requirements, and the correct technique for applying braces and splints

7. The adequacy of relevant policies and procedures in place at [the rest home]
8. Any other matters in this case I consider warrant comment.

I have reviewed the following documents:

1. Letter of complaint dated […]
2. Response from clinical manager at the time of the events, [RN C], dated 15 August 2017
3. [Mr B's] clinical records from [the rest home]
4. Further clinical documents from [the rest home] comprising a fluid balance chart and food diary
5. Clinical records from [the DHB] for March 2017
6. Comments from [Dr E], a General Practitioner associated with [the rest home]

In addition on 20 December 2018 I requested that the Commission seek the following additional supporting documentation from [the rest home]:

1. Policies relating to admission procedures including completion of initial assessment and care plan
2. Policies relating to completion of nursing care plans including short term care plans
3. Any policy relating to completion of Advanced Directives, Advance Care Plan or Medical Care Guidance Plan
4. Any policy documents regarding recognition of and response to residents' clinical deterioration
5. Policies relating to direction and delegation between RN and caregivers
6. Any policy relating to documentation in the clinical notes
7. Policies relating to assessment and management of pain and any relevant documentation including pain assessment form or similar
8. Policies relating to nutrition and hydration including any relevant guidance on completion of fluid balance charts, as well as any relevant documentation such as food diary document or similar
9. Any policy relating to access to specialists such as dietitian, physiotherapist, speech language therapist, community stroke rehabilitation service or similar
10. Any policy regarding communication with family/NOK including how this should be documented in the clinical file
11. Any policy regarding communication with GP
12. Any short term care plans completed during the admission
13. Any pain assessment form completed during the admission

14. Any physiotherapy assessment and plan
15. Any other documentation which records communication with the GP for that period eg relevant faxes to the GP, GP list describing residents who need to be reviewed during a round and why, etc
16. Any other documentation which records communication with family/NOK/EPOA etc

I was advised by the HDC Senior Investigator on 21 February that the providers considered this request for further information and responded that they had no further comment.

Background

[Mr B] was admitted to [the rest home] on 20 October 2016 for Hospital Level Care, having transferred from [a] Private Hospital where he had resided since December 2015 after discharge from [the DHB]. On admission to [the rest home] [Mr B] had a history of extensive Left Middle Cerebral Artery (MCA) infarction 2015, with residual right sided weakness, dysphagia (recent removal of PEG), aphasia and apraxia, and a history of asthma and occlusion of left retinal artery. [Mr B] had a history of weight loss; his EPOA describes his dietary preference as vegan, and he required a soft diet with mildly thickened fluids due to his impaired swallow. Due to right sided weakness [Mr B] required a hand splint, sling, shoulder brace and ankle-foot orthotic (AFO), and mobilised with supervision short distances using a quad stick.

On 19 March 2017 [Mr B] presented to [the public hospital] accompanied by [Ms A], having transported him there from [the rest home] in her car. [Mr B's] [DHB] clinical documentation describes him having presented with one week history of general decline, lethargy, reduced appetite and fevers. He was admitted under general medicine and diagnosed with right lower lobe pneumonia. During the course of his admission [Mr B] was treated with IV antibiotics and IV fluids, and received physiotherapy and speech language therapy input. During his inpatient admission the decision was made for [Mr B] not to return to [the rest home] and he was discharged into the care of a friend to be supported at her home pending admission to an alternative private hospital facility.

1. The adequacy of the care provided to [Mr B] in the days immediately prior to his hospitalisation

[Mr B] was admitted to [the rest home] for Hospital Level Care. During the seven days leading to his admission to [the public hospital] on 19 March 2017, [the rest home's] clinical record evidences review by a Registered Nurse on 12 March at 0300hrs at which time the progress note entry states *'[Mr B] rang the bell to say that he is coughing and has sore throat. Obs done T36.3, BP98/70 please continue to observe him'*. The progress notes over the coming days make intermittent reference to [Mr B] *'not feeling well'* and describing a cough, general lethargy, and reduced appetite, however from the 14/3/17 until the 19/3/17 there is no further record in the progress notes by a Registered Nurse, until the HCA notes describe informing the RN on 19/3 of

[Mr B's] friend noting *'dark coloured and foul odoured urine'* in [Mr B's] urine. [Public hospital] admission documentation describes his condition on 19/3/17 as febrile with a temperature of 38.8°C, and with offensive smelling, concentrated urine. He is noted to have mild dehydration on 20/3/17 and commenced on IV fluids.

[The rest home's] TPR/Basic Observations Chart evidences observations being recorded on 12/3/17 (no time noted), 13/3/17 at 0500hrs and 0800hrs, 14/3/17 at 2200hrs and 2300hrs, 15/3/17 (no time noted), and 19/3/17 (no time noted). No signature or designation of the staff member completing the observations is recorded on the chart, so it is not clear that the RN assessed [Mr B] at these times, however on the 13/3 and 14/3 the entry is consistent with the progress notes from the same time as signed by a RN. There is no documented evidence that [Mr B] was assessed by a RN between 15/3 and 19/3/17.

[Mr B] was seen by the GP (name illegible) on 15/3/17. There is no evidence in the GP's documentation or progress notes that the GP was made aware of the recent history as described in the notes (the GP progress notes describe *'troubled by noise'*, *'blood from chin',* and *'itch ears'* as presenting concerns); no evidence was provided of any communication with the GP describing the background of his condition over recent days, the RN's assessment of [Mr B's] current condition, or recommended outcome of the GP review. The Medication Chart provided does evidence [Dr E] having prescribed PRN medication (Camphorated Opium Tincture 1.6ml/5ml + Oxymel squill 1.66ml/5ml + Tolu syrup 1.66ml/5ml oral liquid — Gee's Linctus) on the 15/3/17 at 1000hrs. No indication for use is provided, however Gees Linctus is commonly prescribed for symptomatic relief of coughs so it would appear the GP was made aware of [Mr B] experiencing a cough on 15/3/17.

The Manager and [RN C] describes in her response having 'kept a close monitor of [Mr B's] condition' following the GP review on the 16/3/17 and 17/3/17, however this is not recorded in the progress notes. No documentation was provided to evidence that a short-term care plan was documented by a RN to guide provision of care in accordance with their assessment in the context of [Mr B's] current condition. No vital signs are recorded on the TPR/Basic Observations Chart between 15/3 and 19/3/17.

The Health and Disability Services Standards (NZS8134.1:2008) require that *'Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers'* (Standard 1.2.8: Service Provider Availability[1]); and that *'Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes'* (Standard 1.3.6: Service Delivery/ Interventions). The Age Related Residential Care Services Agreement[2] further requires that Hospital Level Care services ensure that at least one Registered Nurse is on duty at all times, and that Registered Nurses are responsible for ongoing re-assessment and review of Care Plans, implementation/delegation of nursing tasks, and supervision and provision of care according to each resident's care plan. The RN is responsible for assessment of each resident when their health status changes. Care plans should

include specific interventions for both long term and short term problems as per assessed needs.

Documentation is a key function of all Registered Nurses, as identified in Domain 2, Competency 2.3 of the New Zealand Nursing Council Registered Nurse scope of practice[3]. Domain 1, competency 1.3 states that overseeing the activities of those who report to RNs such as Enrolled Nurses and Caregivers is also the responsibility of the RN. The New Zealand Nurses Organisation guidelines for documentation[4] further states that '*If care is not recorded, then it is assumed the care was not given'.*

Impression
It is apparent from the documentation that [Mr B's] condition had been generally deteriorating for the seven days leading to his acute admission on the 19/3/17. There is insufficient evidence in the clinical documentation that [Mr B] received the appropriate level of oversight and assessment from a Registered Nurse during that time. While [Mr B] was seen by the GP on 15/3/17, there is no evidence that RN assessment of [Mr B's] condition over recent days was adequately conveyed to the GP, and that care provision by HCAs was appropriately directed by a Registered Nurse through documentation of a short term care plan.

I consider that the care of [Mr B] in the days leading to his hospitalisation departed from the expected standard, and that my peers would view this with moderate to severe disapproval.

2. Whether there was appropriate escalation of concerns regarding [Mr B's] condition

As noted above, [Mr B] was reviewed by the GP on Wednesday 15/3/17, however there is insufficient evidence in the clinical file of the GP being informed of the nursing observations which led to the review being requested. While [RN C] describes having observed [Mr B's] condition on Thursday 16/3 and Friday 17/3, this is not evident in the clinical file. There is insufficient evidence of an appropriate degree of RN assessment, monitoring, and evaluation of [Mr B's] condition on the 16/3, 17/3, and 18/3. No short term care plan was made available with the clinical documentation to evidence RN direction of specific interventions in the context of his current condition.

The HDSS require that there is referral to the GP in a timely manner and that there is effective communication between RN and GP to ensure *'Consumers receive adequate and appropriate services in order to meet their assessed needs'* (Standard 1.3.6: Service Delivery/Interventions). The NZNO guidelines for documentation recommend the use of a documentation framework such as the SBARR framework to ensure a structured and standardised approach to communication between health care workers, and describe the SBARR framework as commonly used and particularly useful for reporting changes in a patient's condition or reporting deterioration.

[Ms A] describes being concerned regarding [Mr B's] condition on visiting during the morning on the 19/3/17 and requesting a RN check his temperature. [Ms A] describes

requesting that [Mr B] be medically reviewed, and that on being advised by the RN on duty that the on call doctor was not able to be contacted, made contact with the medical registrar at the public hospital and arranged for his acute admission. An entry by an RN in the progress notes at 1230hrs on 19/3/17 records [Mr B's] observations, with T38.6°C, and that *'[Ms A] insisted to take to hospital, Manager [RN C] and [Dr E] informed'.*

GP [Dr E] states in his response that neither on call GP took a call on Sunday 17/3/17 (however notes that on occasion a GP may not take a call due to sometimes being otherwise engaged at the time, but that they will usually respond within an hour or two) and notes that *'It appears the nurse did not persist because a decision was taken quite quickly to send [Mr B] to hospital'*.

[RN C's] response describes an understanding that the preference of [the DHB] is for aged care facilities to *'manage residents in the community if possible, rather than sending them to hospital'* and notes that on occasion [the rest home] RNs have been *'told off by sending patients to [the public hospital] without approval from the on call medical registrar'*. [RN C] describes [Ms A] as having identified [Mr B's] condition on 19/3, and [Ms A] having been able to access medical advice more promptly than the RN on duty. [The rest home's] policy regarding recognition of and response to residents' clinical deterioration was requested but not provided.

Impression

There is no evidence of RN assessment or oversight of [Mr B] for three days following the GP review on 15/3/17. As described above oversight of the care of HLC residents by a RN is required under the HDSS and ARRC contract, as well being a professional obligation of a Registered Nurse. [RN C] states that on the morning of 19/3 [Mr B's] deteriorated condition was first observed by [Ms A] rather than by [rest home] staff. Overall I consider that there was a lack of appropriate assessment, critical thinking, and action in response to [Mr B's] deteriorating condition, and I consider this a departure from the expected standard. I believe my peers would consider this departure with moderate to severe disapproval.

3. The adequacy of the clinical documentation

[Mr B] was admitted to [the rest home] on 20/10/16, and an initial assessment and care plan was completed. A nursing care plan is documented as having been completed by a RN on 6/11/16, and an InterRAI assessment commenced on the 8/11 with the final date of entry apparent on the 11/11/17. There was no InterRAI reassessment subsequent to the initial assessment. Progress notes have been entered at least daily from admission until transfer to hospital on 19/3/17. The HDSS require that the Care Plan should describe specific interventions to address residents' care needs as identified through assessment (Standard 1.3.3: Service Provision Requirements). Services should be coordinated in a manner that promotes continuity, and the Care Plan is the means of communicating how the residents assessed needs are to be met; RNs and HCAs then follow the care plan and report progress against the

care plan in the progress notes. Formal care plan evaluations should occur every six months or as residents' needs change, and short term care plans should be initiated for short-term concerns (Standard 1.3.8: Evaluation). The ARRC contract further requires that changes in a resident's condition should be documented 'either by amending the Care Plan or as a separate short-term Care Plan attached to the Care Plan'.

Neither the Initial Assessment and Care Plan completed on 20/10/16 nor the Nursing Care Plan completed on 6/11/16 is consistent with [Mr B's] current assessed needs as described in the progress notes. No evaluation or review of the care plan completed on 6/11/16 is apparent, and no short term care plans were provided on request therefore there is no evidence any short term care plans were completed in response to acute problems or short term needs.

Examples of inconsistencies evident in the documentation include:

- Initial RN progress notes entry on admission on 20/10/16 describes [Mr B] as requiring 'shoulder braces and right foot braces on while walking as well as arm sling. To put right hand braces 2hrs on and 2hrs off as informed by his EPOA'. [Ms A] describes having been present for the initial assessment and satisfied that she was able to 'give them plenty of information about [Mr B's] needs and care requirements'. These interventions are not documented in the Initial Assessment and Care Plan completed on the same date, and the Care Plan completed on 6/11/16 mentions only 'to ensure his foot splint is on while walking' as a required intervention for 'Safety'; [Mr B's] shoulder brace, sling, hand splint are not mentioned in the care plan
- Progress notes completed by Physio 18/11/16 with advice re shoulder support, hand splint, and AFO, as above these instructions not reflected in the care plan
- The Nursing Care Plan completed on 6/11/16 describes [Mr B] as having 'no pain' however the InterRAI assessment completed 11/11/2016 describes him as requiring 'Gabapentin for pain. Also has prn Panadol for pain'. GP progress note entry on 8/12/16 states 'EPOA requests stop Gabapentin and baclofen ... Stop and observe' ; no corresponding documentation in progress notes or short term care plan are evident, and there is no evidence of corresponding pain assessment or monitoring over coming weeks. 18/1/17 GP progress notes entry describes 'R sided facial pain — very long Hx neuropathic pain ... Retrial Gabapentin'. Evidence of a text message to [Ms A] on 22/1 refers to [Mr B] having complained of neuro pain prior to being restarted on Gabapentin by the GP the previous week and with no further complaints of pain however again there is no evidence of pain assessment or reference to this pain in the progress notes.
- Progress notes describe review by Dietitian on 8/12/16 noting 2kg weight loss over two months, with recommendation for high calorie diet — no evidence of review of Care Plan and no corresponding short term care plan evident. [Mr B] is reviewed again by the dietitian on 10/2/17 who now notes 3.6kg weight loss since

seen in December, and advises interventions to address which again there is no evidence to suggest have been communicated clearly in a short term care plan.

The progress notes do evidence that external allied health advice was sought for [Mr B], and their assessment and recommendations were documented in the progress notes. No further written documentation has been provided however to evidence that these recommendations were communicated to the care team other than in the progress notes.

As described above, residents assessed as requiring hospital level care have been assessed as such due to the complexity of their condition and the need for an RN to oversee their care on a 24 hour basis. Standard 1.2.8: Service Provider Availability requires that *'Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers'*; and the ARRC contract requires that the RN is responsible for *'supervision and provision of care according to each resident's Care Plan'*. RN oversight of [Mr B's] care is evident through the weeks following his admission to [the rest home] on 20/11/16, with frequent RN entries in the progress notes throughout October and November 2017. However from December 2016, there is inadequate evidence in the clinical documentation of RN oversight of [Mr B's] care. There is a single RN entry evident during December, on 8/12/16, and two entries during January (3/1/17, and 4/1/17), with no entry identifiable as RN during February 2017. The next entry in the progress notes identifiable as a RN is 12/3/17. It is noteworthy that during this period of apparent lack of RN oversight, on 10/2/17 the Dietitian notes in [Mr B's] progress notes that he has lost 3.6kg since the last Dietitian review on 8/12/16, which coincidentally is the date of the most recent RN progress note entry.

Evidence of text messages between [RN C] and [Ms A] has been provided, from which it could be inferred that [RN C] was providing some degree of oversight of [Mr B's] care. These include text messages sent during January 2017. This oversight is not reflected in the clinical documentation provided. [Mr B] was seen by the GP on 8/2/17, at the RN's request following a fall (with an associated RN entry in the progress notes on 8/12/17) and then at least monthly during January and February, so again it could be inferred that there was RN involvement in the GP review. There are some corresponding entries on the TPR/Basic Observations Chart which align with the dates of GP progress notes entries, with no signature or designation provided, which are most likely to have been completed by an RN.

Impression

I am highly critical of the adequacy of clinical documentation, and in particular the degree to which the documentation provides evidence of an appropriate level of RN oversight given [Mr B's] condition and level of care required. The facility's policies regarding documentation in the clinical notes, and direction and delegation between RN and caregivers, were requested but not provided. As above the NZNO guidelines for documentation state that '*If care is not recorded, then it is assumed the care was not given'.* The guidelines further state that entries must be legible, and include

designation eg RN. It must therefore be assumed that there was an inadequate level of RN oversight of [Mr B's] care during December 2016, and January and February 2017, and this is further supported by the deterioration in [Mr B's] condition through this time with significant weight loss evident between December and February.

I consider the clinical documentation departed from the expected standard, and that my peers would view this with severe disapproval.

4. The adequacy of the services provided to [Mr B] in light of his previous stroke

[Mr B] is described as having experienced an extensive Left MCA infarction in 2015, with residual right sided weakness, dysphagia with recent removal of PEG, aphasia and apraxia. [Ms A] describes having been reassured by the Eldernet website that [the rest home] offered Stroke Rehab and other services, and that [RN C] was known to her having previously worked as an RN at [the DHB rehabilitation service] when [Mr B] was a patient there. [RN C] describes herself as experienced in stroke rehab, and further states [rest home] HCA staff as 'trained to look after stroke patients' eating, drinking, personal cares, hygiene, toileting, mobility, etc'.

[Ms A] describes being confident at first that 'things seemed to go well' on admission to [the rest home]. Indeed, there is evidence in the documentation of an appropriate degree of involvement from external allied health, with referrals made to Physio, Dietitian, and Speech Language Therapist, and their assessment and recommendations documented in the progress notes. [Mr B's] medical history meant that his nursing care needs were complex in order to maintain his physical and psychosocial wellbeing. It is critical that these care needs are clearly communicated to all staff through the nursing care plan, and that this is evaluated and updated when those needs change. It is also critical that a resident assessed as requiring hospital level care has that care overseen by an RN at all times.

As described above, an appropriate level of RN involvement in and oversight of [Mr B's] care is apparent in the clinical documentation during October and November 2016. While as above I am critical of key information about the interventions to support [Mr B] not having been documented in the nursing care plan to ensure continuity of care and visibility of key information, the progress notes do at least evidence clear instructions for his care in response to RN assessment during that period. Capturing such information in the progress notes however does not negate the requirement for a thorough and up to date care plan. RNs and HCAs cannot be expected to read back through weeks and months of progress notes to find key information to guide their care on a shift by shift basis, therefore key information about caring for [Mr B] in the context of his complex needs was not accessible to staff and this represents a significant risk.

I am further highly critical as above of the lack of apparent RN oversight of [Mr B's] care from December 2016. There is insufficient evidence to suggest that care delivery was not led by HCAs throughout this period, given the lack of evidence of RN input in the clinical documentation. This is further supported by the decline in [Mr B's] health

during this period, for example as evidenced by significant weight loss. This is highly inappropriate given the complexity of [Mr B's] needs.

Impression
Overall however I am highly critical of the care provided to [Mr B] in the context of his complex needs. I view his care provision in light of his previous stroke to have departed from the standards expected, and consider my peers would view this with severe disapproval.

5. [Mr B's] oral intake and weight loss

As above, there are several inconsistencies in the clinical documentation provided, and a lack of an appropriate degree of RN oversight evident. This extends to [Mr B's] oral intake and weight loss as it does for other aspects of his care. For example, [Ms A] describes [Mr B] as having a vegan diet; the care plan completed for [Mr B] describes him as vegetarian. [RN C] also describes [Mr B] as vegan in her response. [Mr B's] cultural considerations are described in the nursing care plan as '[religious affiliation]'.

[Mr B] had known dysphagia due to his stroke, and had recently had a PEG removed, with a known history of poor oral intake. As above, SLT and Dietitian input was sought in the context of [Mr B's] complex needs and his poor oral intake and weight loss, however allied health recommendations were not reflected in the care plan. On 8/12/16 the Dietitian recommended weighing [Mr B] weekly; this instruction is not followed up with the Weight Chart showing that [Mr B] was only weighed a further eight times between 19/12/16 and his transfer to hospital on 19/3/17.

[RN C] describes [Mr B] as having 'never been a good eater in his life. He was 40 odd kg before his stroke'. On admission to [the rest home] [Mr B's] weight is recorded as 57.6kg. [RN C] further states that as a vegan, [Mr B] may have had less food choices available and that staff tried very hard to meet his needs, with staff even bringing food from home for him on occasion. Given the acknowledged challenges of meeting [Mr B's] needs and preferences, it would be expected that the care plan clearly stated his dietary preference (vegan or vegetarian) and agreed interventions.

[RN C] describes having commenced [Mr B] on a fluid balance chart and food diary, and the clinical documentation provided includes 'Fluid Balance Charts' which appear to have been completed almost daily from 16/11/17 until his discharge. The Fluid Balance Charts have been used to record both food and fluid intake, which is not usual practice. Policies relating to nutrition and hydration including any relevant guidance on completion of fluid balance charts, as well as any relevant documentation such as food diary document or similar, were requested but not provided by the facility. As with other aspects of [Mr B's] care, these interventions are not reflected in the care plan.

The HDSS Standards require that *'A consumer's individual food, fluids and nutritional needs are met'* (Standard 1.3.13: Nutrition, Safe Food, And Fluid Management), and the ARRC contract states that the service must provide '*a food service of adequate and*

nutritious meals, and refreshments and snacks at morning/afternoon tea and supper times, that reflects the nutritional requirements of older people, and as much as possible takes into account the personal likes/dislikes of the Resident, addresses medical/cultural and religious restrictions, and is served at times that reflect community norms'.

Impression
I am critical that in the context of a lack of RN oversight as described earlier, while [Mr B's] intake was dutifully recorded by HCAs throughout his admission and Dietitian review was accessed, there was a lack of nursing assessment, review, and application of clinical judgement by RNs in [Mr B's] care, which is again relevant to his oral intake and weight loss, and therefore no outcome of that assessment and corresponding change in the plan of care evident. Ensuring [Mr B's] nutritional needs were met was a key component in maintaining his physical health, however individuals' relationship with food is also an important aspect of cultural and psychosocial wellbeing. I am critical that insufficient attention was paid to [Mr B's] preferences (for example vegan vs vegetarian), and find [RN C's] statement that [Mr B] was '40odd kg before his stroke' ill-considered and inappropriate in this context.

I consider the service's support for [Mr B's] oral intake and his subsequent weight loss to be a departure from the expected standard, and consider that my peers would view this with moderate to severe disapproval.

6. The appropriateness of requesting clinical input from [Ms A] about [Mr B's] care requirements, and the correct technique for applying braces and splints

[Mr B] is noted as having aphasia and apraxia, and having an inability to express his needs verbally. The involvement of [Ms A] in obtaining a history as to his needs and preferences would be expected, and [Ms A] describes being confident in the comprehensive assessment completed by the RN on [Mr B's] admission, for which she was present and able to share key information. It is usual practice to involve key relatives and loved ones in the process of gathering information to inform care, with the resident's consent, and the InterRAI assessment notes that [Ms A] holds EPOA for [Mr B] which had been activated on 8/4/16.

The Physiotherapist who reviewed [Mr B] on 18/11/16 describes having documented a plan of care for [Mr B], and documents instructions about shoulder support, hand splint, and ankle-foot orthotic (AFO) in the progress notes. The physio's plan of care was not provided for review. As stated earlier, these instructions are not reflected in the nursing care plan which refers only to a 'foot splint' to be worn while walking, and no other care plans were provided.

[Ms A] describes her frustration with a lack of continuity of care and staff needing to be reminded about the shoulder splint, hand splint and AFO, and that she felt the need to demonstrate to staff how these should be applied herself, during a shift handover. It is not unusual for a relative or loved one to hold detailed knowledge of the specifics of elements of a resident's care needs, and where they wish to be

involved in supporting staff understanding of their loved one's needs this is usually welcomed. It would be expected however that their advice is clearly communicated to ensure continuity of care, and to ensure that this involvement feels like a valued contribution rather than a burdensome requirement for fear that the information will otherwise be lost. The lack of clear instruction to staff regarding proper application of supportive equipment in this case is consistent with the inadequacies noted in the clinical documentation above. It would be expected that clear instructions were made available for staff as to how and when the supportive equipment should be applied. It is common practice for example for photos to be available to staff showing the correct positioning, and certainly would be expected that these instructions would be clearly described in the care plan.

Impression

I am highly critical as stated earlier that the nursing care plan did not reflect the instructions from the Physiotherapist, and I find that while it was appropriate to involve [Ms A] in articulating [Mr B's] care needs to staff if that was her wish, it would appear she felt moved to do so out of concern for [Mr B's] welfare due to a lack of continuity of care and apparent lack of awareness of the interventions required. I consider this a departure from the expected standard, and feel my peers would view this with moderate disapproval.

The adequacy of relevant policies and procedures in place at [the rest home]

I am unable to comment on the adequacies of relevant policies and procedures as while these were requested none were provided.

Any other matters in this case I consider warrant comment.

[RN C] comments in her response about [Ms A's] desire for [rest home] staff to administer medical marijuana to [Mr B], and notes that this presented an ethical dilemma to the RNs. [RN C] also states that she suspected [Ms A] of illegal activity in possession of an illegal substance. These comments are not supported by any reference to the same in the clinical documentation (nursing progress notes or GP progress notes) or referred to in the email or text communications provided. [The rest home's] policy regarding communication with family/NOK including how this should be documented in the clinical file was requested but not provided.

The New Zealand Nursing Council Code of Conduct[5] requires that nurses 'Act with integrity to justify health consumers' trust', and in particular 'Protect vulnerable health consumers from exploitation and harm' (Principal 7.2), and 'Act promptly if a health consumer's safety is compromised' (Principal 7.3). The Code of Conduct requires that nurses 'Maintain health consumer trust by providing safe and competent care' (Principal 4) and in particular keep clear and accurate records (Principal 4.8). Failures with regard to documentation are referred to throughout his advice, however are also of note here. As noted earlier, accurate documentation is a key function of all Registered Nurses, as identified in Domain 2, Competency 2.3 of the New Zealand Nursing Council Registered Nurse scope of practice. Should there have been requests

for [Mr B] to be prescribed medical marijuana or concerns that marijuana was being offered by friends or family this should have been documented in the clinical file and appropriate action taken, for example but not limited to discussion with [Mr B's] GP.

[RN C's] comments are unsupported by any evidence in the documentation provided. The Code of Conduct requires that nurses 'Maintain public trust and confidence in the nursing profession' and that nurses 'Maintain a high standard of professional and personal behavior' (Principal 8.1). I am critical of [RN C's] response to this complaint and find the comments unprofessional.

I acknowledge that my conclusions are limited by a lack of information, with many of the items of supporting documentation not provided on request.

I am happy to be contacted for further advice should this be required.

Naku, ngā

Kate Lopez

1 https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf

2 https://tas.health.nz/assets/Health-of-Older-People/Age-Related-Residential-Care-Services-Agreement-2018.pdf

3 http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse

4 https://www.nzno.org.nz/LinkClick.aspx?fileticket=GH84aNBNd64%3D&portalid=0

5 http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct"