Registered Nurse, Ms D

Registered Nurse, Ms C

Belhaven Rest Home Limited

A Report by the

Acting Health and Disability Commissioner

(Case C09HDC01035)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

After short periods of respite care at Belhaven Rest Home (Belhaven) from 11 September 2004, Mrs A became a permanent resident from 20 October 2005. On 2 November 2006, she was assessed as eligible for dementia care and was transferred from the rest home to the "Lodge" (dementia unit).

Mrs A had dementia, heart failure, renal failure, breast cancer, hypertension, postural hypotension and anaemia. Her daughter, Mrs B (herself a registered nurse), had an enduring power of attorney (EPOA) for Mrs A's personal care and welfare.

From the beginning of October 2008, Mrs B noticed that her mother's condition was deteriorating.

On 16 October 2008, Mrs A was transferred to a private hospital. On arrival she was assessed and photographs were taken of large black blisters on each heel, and excoriation around her vulval and perineal areas and left hip. A few days later, Mrs A died (aged 91).

This report considers the care provided to Mrs A at Belhaven Rest Home from 9 April 2008 to 16 October 2008.

Complaint and investigation

On 23 March 2009, the Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs A, by Belhaven Rest Home Limited (Belhaven). The following issues were identified for investigation:

Whether clinical nurse manager Ms C provided Mrs A with reasonable treatment and care between 9 April 2008 and 16 October 2008.

Whether Ms C adequately informed Mrs A and her family about Mrs A's condition and treatment.

Whether Belhaven Rest Home provided Mrs A with appropriate treatment and care, including:

- *skin and wound care*
- *accident/incident reporting*
- *reassessments for hospital level care*.

An investigation was commenced on 22 May 2009.

On 9 July 2009, the investigation was extended to include:

Whether registered nurse Ms D provided Mrs A with reasonable treatment and care between 9 April 2008 and 16 October 2008, including:

- *skin and wound care*
- *accident/incident reporting*
- *reassessments for hospital level care.*

Whether Ms D adequately informed Mrs A and her family about Mrs A's condition and treatment.

The parties directly involved in the investigation were:

Mrs B	Complainant
Ms C	Provider/registered nurse/nurse manager
Ms D	Provider/registered nurse
Belhaven Rest Home Limited	Provider

Information was reviewed from the above listed parties and also:

Mr E	Mrs A's son
Mr F	Mrs A's son
Ms G	Nurse practitioner
District Health Board CEO	
Dr H	Provider/general practitioner
Ms I	Private hospital nurse manager

Also mentioned in this report:

Ms J	Rest home director
Mr K	Rest home director
Ms L	Rest home director

Independent expert advice was obtained from registered nurse Noeline Whitehead (attached as **Appendices A, B and C**).

Information gathered during investigation

Belhaven Rest Home
Belhaven Rest Home (Belhaven) is a privately owned facility. It provides 25 rest home beds and 11 dementia care beds. Belhaven was certified in October 2007 for three years.

A family established Belhaven in 1983. The rest home is operated by Belhaven Rest Home Limited. Ms J, Mr K and Ms L are all directors. There has been a succession of managers, nurse managers and registered nurses during recent years.

Ms J stated that the directors "normally handed the reigns over to the manager but have continued to work at the Home". At the time of these events, she assisted with the shopping, taking the residents out and public relations. Mr K took care of workplace health and safety, gardening and maintenance. Ms L assisted with time sheets, rostering and recruitment.

There were no regular formal meetings between senior staff and the directors. Ms J advised that the directors monitored the quality of care being provided through the accreditation audits. She also stated that incident reports were completed by staff and given to the manager, Ms C, for follow-up action, but they were never given to any of the directors.

Ms J stated that the directors did not sign off on changes Ms C made to Belhaven's policies and procedures — "the Directors effectively took a step back from overseeing Belhaven".

RN Ms D

In February 2007, Ms D began working part-time at Belhaven. On 31 March 2008, she was appointed as the registered nurse, working five days a week, but her hours were later reduced to three days a week from August 2008, owing to a decline in the number of residents at Belhaven.[1] Ms D resigned on 25 September 2008 owing to a deteriorating working relationship with Ms C and the directors. The registered nurse position at Belhaven was not filled until 10 November 2008.

Ms D provided a description of her responsibilities. These included:

- daily supervision of caregivers, care, medication administration
- supervision of residents' care and ensuring care maintained at a high level
- communication with family/whanau in her hours of work
- referrals to allied health services — Needs Assessment/Service Coordination, general practitioner, physiotherapist, dentist, dietician
- once monthly weights and observations on all residents
- liaison with general practitioner and accompanying the general practitioner on his/her round
- organising three-monthly reviews with family, general practitioner and resident
- informing family of any changes to a resident's state of health.

Ms D does not recall signing an Employment Agreement, or being given a job description.[2]

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[1] On 10 September 2009, Ms C stated that Ms D was working about 20–24 hours a week and that the industry standard was one hour of RN per resident. Ms C stated that the shortfall in hours was not made up by anyone and that Ms D's hours were set by the directors.

[2] The Employment Relations Act 2000 requires a written employment contract, which must include a description of the work to be performed by the employee.

RN Ms C
Ms C is a registered nurse. On 1 April 2008, she was appointed full time as manager at Belhaven. Ms C covered for Ms D when she was on leave (16 April to 5 May 2008, 4 July to 21 July 2008) and on the week days she didn't work. After Ms D left on 25 September 2008, Ms C was the sole registered nurse at Belhaven. She was on call at night and in the weekends. From 4 February 2009, her position was changed to registered nurse following a restructure. She resigned on 27 April 2009.

Ms C provided a description of her responsibilities as manager. They included:

- maintaining a working relationship with the directors and keeping them informed of operations
- developing and introducing new policy and procedure manuals
- developing and maintaining quality systems
- keeping data, including:
    - incidents and accidents
    - wound management
    - infection control and antibiotic usage
    - resident Body Mass Index (BMI)
- dealing with resident and relative enquiries.

In respect of her relationship with the directors, Ms C stated:

> "Any time I had [an] idea to improve the business which was different from the way things had been done previously we discussed it and came to a decision. This included the comfort money, making care plans user friendly and easy to follow, how to handle media enquiries when [another Belhaven facility] made headlines, rearranging the front office/reception area to be more visitor friendly, making the policies and procedures easy to find on the computer in a logical setting, moving the laundry from upstairs to downstairs so laundry could be attended overnight as well as day time."

Ms C organised monthly training sessions for the staff. These included sessions on behaviour and infection control, which were held during the period under investigation.

In June 2009, Ms C told HDC that she had been employed as a "manager who happened to be a registered nurse" and "clinical responsibility fell with the Registered Nurse. I did not hold this position between [9 April 2008 and 16 October 2008]".

On 10 September 2009, Ms C stated:

> "I did not identify any issues with the care [Ms D] was providing when I covered for [Ms D] during school holidays and after [Ms D] resigned. I was her manager as I was the manager of everybody.

…

> There was no requirement in my contract to provide RN cover for a set period of hours each week. I made a distinction between a clinical nurse manager, which in small rest homes is usually a sole charge RN and a rest home manager. I did not see myself as [Ms D's] clinical supervisor. We did discuss the care of particular patients and possibly saw some patients together."

Ms C's employment contract, dated 9 April 2008, refers only in passing to her position as manager. None of the job descriptions for the registered nurse and manager are signed. However, the manager's position description requires "effective oversight of the clinical environment including the implementation of legislative standards and systems for monitoring and evaluation of services provided". The manager's job description provided by Belhaven states that the manager would:

> "ensure the Directors receive monthly reports that are timely, contain effective operational analyses, and recommendations that are sound with contingencies planned for.
>
> …
>
> Ensures that all monthly Directors papers are prepared in a timely manner and provides Directors with current information relating to service delivery."

No evidence has been provided that these monthly reports were done.

Ms D and Ms J are adamant that Ms C was employed as Nurse Manager. Ms C signed a contract variation with the DHB on behalf of Belhaven as "Nurse Manager" on 19 June 2008. Psycho-geriatric nurse practitioner Ms G[3] also commented that Ms C supervised nursing care when Ms D was not on duty. Ms C stated:

> "I agree that I provided minimal nursing care to [Mrs A] as this was not part of my role at Belhaven. If [Ms D] was not on the premises, as she worked part time, I did what a registered nurse needed to do in an emergency."

In relation to Ms C's employment, Belhaven advised:

> "[Ms C] was employed as the Registered Nurse and Manager. The directors had taken this approach as we do not have any medical background and at the time did not believe we could be involved in the medical treatment of the residents of Belhaven. [Ms C] had the full rights to hire whatever staff was required for the operation of the rest home. She was given full financial support from the Directors for all she need[ed] to purchase. The Registered Nurse/Manager was responsible for the training of staff."

[3] Ms G works for the DHB's Mental Health Services for Older People and was available on call to assist Belhaven.

Aged Residential Care Agreement
Belhaven's Aged Related Residential Care Agreement with the DHB states that:

> "[e]very Rest Home must engage a Manager who holds a current qualification or has experience relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Rest Home; and
>
> The role of the Manager includes, but is not limited to, ensuring the Subsidised Residents of the Home are adequately cared for in respect of their everyday needs, and the services provided to Subsidised Residents are consistent with obligations under legislation and the terms of this Agreement.
>
> …
>
> You must employ, contract or otherwise engage at least one Registered Nurse, excluding a registered psychiatric nurse, who will be responsible for working with staff and (where that Registered Nurse is not the Manager) the Manager to:
>
> i. assess Subsidised Residents:[4]
>
> 1. on admission;
> 2. when the Subsidised Resident's health status changes;
> 3. when the Subsidised Resident's level of dependency changes;
> 4. at each 6 month review date in accordance with Clause D16.4(a).[5]
>
> ii. develop and/or review Care Plans in consultation with the Subsidised Resident and family/whanau;
> iii. advise on care and administration of medication, possible side effects and reported errors/incidents;
> iv. provide and supervise care;
> v. act as a resource person and fulfil an education role;
> vi. monitor the competence of other nursing and Care Staff to ensure safe practice;
> vii. advise management of the staff's training needs;
> viii. assist in the development of policies and procedures.
>
> Where there is more than one Registered Nurse in your Facility, the duties and responsibilities assigned to the Registered Nurse may be shared between the Registered Nurses On Duty over a 24 hour period."

[4] These are residents who are eligible for rest home subsidies from the DHB. Mrs A was a Subsidised Resident from 28 October 2005.
[5] Clause D16.4(a) states: "You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, whichever is the earlier."

Medical cover
Belhaven has an arrangement with general practitioner Dr H to provide care to all its residents. In addition, other health professionals, such as Ms G, visit regularly.

Mrs A

Mrs A lived in Belhaven's dementia unit from November 2006. She had previously had two falls, fractured her left hip,[6] had breast cancer, and had a number of long-term conditions including: acute pulmonary oedema,[7] hypertension,[8] postural hypotension,[9] severe dementia, severe heart failure and normochromatic normocytic anaemia.[10] Following discharge from a public hospital in January 2008, Mrs A was on a number of medications including:

Blister packed:
- Diurin 40 (furosemide)[11]
- Anten (doxepin hydrochloride)[12]
- Inhibace (cilazapril)[13]
- Genox (tamoxifen citrate)[14]
- Ridal (risperidone)[15]
- Heartcare Aspirin (aspirin)[16]
- Span-K (potassium chloride)[17]
- Dilatrend (carvedilol)[18]

As required:
- paracetamol
- laxsol[19]

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[6] A sacral insufficiency fracture with bruising and tissue damage that gave her great difficulty in walking.
[7] Acute pulmonary oedema is the accumulation of fluid in the lungs due to failure of the heart to remove the fluid.
[8] Hypertension is an elevated blood pressure, which can lead to swelling in the legs.
[9] Postural hypotension is a sudden drop in blood pressure when a person stands, causing dizziness.
[10] Normocystic normochromatic anaemia is a reduction in the number of red blood cells in the blood, which carry oxygen around the body, leading to fatigue
[11] A diuretic (increases urine production) to treat congestive heart failure and oedema (abnormal accumulation of fluid).
[12] An antidepressant.
[13] An ACE (angiotensin-converting enzyme) inhibitor to treat high blood pressure and congestive heart failure.
[14] An antagonist of the estrogen receptor in breast tissue and is used in endocrine (anti-estrogen) therapy for hormone-positive early breast cancer.
[15] An atypical antipsychotic drug to treat schizophrenia, bipolar mania and autism. It can also be used in lower doses (<4mg a day) to treat behavioural problems in elderly people with dementia.
[16] To help prevent heart attacks, strokes, and blood clot formation in people at high risk for developing blood clots.
[17] An electrolyte replenisher.
[18] A beta blocker to treat high blood pressure, angina and heart attacks.
[19] A laxative to treat constipation.

- lactulose.[20]

Mrs A's daughter, Mrs B (herself a registered nurse), had an enduring power of attorney (EPOA) for Mrs A's personal care and welfare, and expected to be consulted, particularly if there were concerns regarding her mother's ongoing health status.[21] Mrs B does not recall whether she told Belhaven she had an EPOA for her mother, and Belhaven did not have a copy in Mrs A's file. Mrs A's mental competency does not appear to have been formally assessed to give effect to the EPOA.

Mrs B and her brother, Mr E, were listed as next of kin on the admission form, and Mrs B later signed informed consent forms on behalf of her mother.[22]

On 14 November 2007, a registered nurse recorded that Mrs A was stable clinically and medically. Mrs B recalls that her mother was well cared for up until she became immobile in her last few weeks at Belhaven. Mrs A would say, "The girls are kind, the meals are lovely, but there is no place like home."

April 2008
In April 2008, Mrs A was slowly mobile on a walking frame, fed herself, and needed assistance with showering and dressing. She was reported to have periods of wandering, agitation and being sleepy. From 27 April, Mrs A reported pain in her legs and was often given paracetamol.

May 2008
In May, Mrs A continued to have periods of agitation, being tired and sleepy, and frequent episodes of pain. From 22 May, paracetamol was inserted into Mrs A's medication blister packs[23] rather than being provided as needed.

June 2008
In June, Mrs A's aggressive episodes and the degree of aggression increased. Caregivers continued to report that Mrs A was at times sleepy.

Ms C later commented:

> "[Mrs A's] general behaviour became more of a problem. [Mrs A] became more aggressive more often. [Mrs A] was being treated with medication for her aggression and typical of little old ladies when you increase their medication slightly you tip them from being aggressive to being docile and not able to do anything. So you change their medication again and they go back to being aggressive and because their bodies react so strongly to a change in their

[20] A laxative to treat constipation.
[21] EPOA signed 19 February 2002.
[22] Informed Consent Form, Withdrawal of Consent for Care/Treatment, and Medical Information Release Consent signed by Mrs B on 21 August 2007.
[23] Two 500mg tablets four times a day.

> medication it's not easy thing to say right we will give her this much more and she will be OK."

Mrs B stated:

> "I was unaware of Mum's aggression, and that was behaviour that I had never seen her display before, ever. Had I been informed, I would have willingly come to Belhaven and sat with her for a time. This would have been helpful for her demeanour and wellbeing and also would have assisted the staff in their care of Mum."

On 24 June, a caregiver found Mrs A on the floor at 9.30pm. Her face was red, swollen and bruised.

On the morning of 25 June, Mrs B visited her mother. Mrs B had not been contacted about the bruise.

Ms C recalls that when she arrived at work she was called down to the Lodge by Mrs B. Ms C said she had not had time to read the incident forms or communication books. She saw Mrs A and wrote in the progress notes, "light bruise on R) face/cheeks". Ms C stated: "My work practice is to notify the next of kin in the event of accidents or incidents."

Ms D recalls seeing Mrs A with a large bruise on her face on that morning. Ms D recalls a caregiver telling her that Mrs A had fallen during the evening or overnight, and Ms C had been called. Ms D stated that incident forms that specifically related to overnight incidents were left on Ms C's desk. Ms D said she arranged for Mrs A to be seen by Dr H (not recorded by Dr H). Ms D recalls being present at that consultation, including witnessing Dr H feeling Mrs A's jaw to check for breaks.

On 26 June, Ms C wrote on the incident form, "slight bruise to face".

On (Saturday) 28 June, a caregiver noticed a rash in Mrs A's groin. An unidentified cream was applied. According to Mrs A's care plan, Lemnis Fatty Cream could be used as required. On (Monday) 30 June, a caregiver recorded in the progress notes that Ms D had been informed of the rash.

July 2008

In July, caregivers continued to report Mrs A as either being tired and sleepy or agitated and aggressive. From July onwards, Mrs A sometimes refused paracetamol and reported being in pain.

On 2 July, the groin rash was bleeding. Ms D recalls that she had "instructed the caregivers to do proper washes and things and it cleared up in two days but then it came back". Ms D remembers telling staff that Mrs A needed to be toileted and to have pads only at night, and for her to be toileted if she got up at night. She did not record this instruction in Mrs A's care plan or progress notes and did not start a wound care plan.

Belhaven's Wound Management Procedures policy (dated 3 April 2008) states:

> "When Registered Nurse/Manager is notified that a resident has a wound, skin tear, skin problem they will investigate and decide the best possible treatment … the treatment is then written in care plan … RN will follow up and sign off when wound is healed."

Ms D was on leave from 4 July to 21 July 2008. She said that she had given caregivers verbal instructions to use fewer incontinence products, toilet Mrs A regularly, wash and dry her carefully, and then apply barrier cream to her groin. Ms D stated:

> "The barrier cream instruction was however removed and staff were told to only use cornflour. I was informed by a caregiver that [Ms C] had given this instruction when I was on holiday."

Ms D said that a caregiver informed her that her instructions weren't always followed.

Ms C later stated that the "cornflour appeared to be working" and "Johnson & Johnson know cornflour works really well as they now produce it like a baby powder".[24]

"Barrier" or "Lemnis" cream was recorded in the progress notes as being applied on 3, 8, 9, 10 and 14 July. There were no progress notes for 4, 5 and 18 July. Cornflour was first recorded as being applied on 21 July.

On 7 July, a caregiver recorded in the progress notes that Ms C was aware of the rash. The rash was queried as either a urine scald or fungal. Ms C considers that at no time did Mrs A require a wound care plan for her groin rash. The following was written in the progress notes (signature unknown):

> "Give good hygiene: wash area & dry well but carefully each time [Mrs A] is toileted. [Twice daily] shower if able to tolerate."

The progress notes show that the rash was improving between 8 and 10 July, but was worse and very itchy again by 12 July. By 16 July, the rash had improved and, on her return from holiday, Ms D noted that the rash was not as red but still itchy.

On 24 July, Dr H examined the rash and noted that it was improving and prescribed Pimafucort ointment. Some caregivers documented applying the cream in the progress notes but not on the medication chart. Ms D recalls reminding staff about toileting and cleaning.

[24] The Johnson's website advises against using their cornstarch baby powder on broken skin. Retrieved on 11 November 2009 from http://www.johnsonsbaby.com.

August 2008
Throughout August, caregivers continued to report Mrs A's vulval/perineal rash. On 12 August, the rash was noted as not improving and a rash was noted under Mrs A's breasts.

On 3 August, Ms D completed a Tinetti Gait and Balance form[25], a Folstein Mini Mental Status Examination form[26] and a Yesavage Geriatric Depression Scale form[27] for Mrs A. On 7 August, Ms D also completed a Norton Scale form[28] and a Coombe Assessment form[29] for Mrs A. The assessments indicated that Mrs A was: mildly depressed, at low risk for pressure ulcers and medium risk for falls. Evaluations were noted on the assessment forms.

Ms C stated that she introduced these assessment tools, some of which Ms D had not used before. Ms C stated that Ms D would complete the assessment and then Ms C would type the care plans on the computer as Ms D was not computer literate. No care plan was developed for Mrs A following these assessments.

On 14 August, Dr H conducted a routine three-monthly medical review of Mrs A. He prescribed Lamisil orally for one month for Mrs A's breast and groin rashes. The next day, nurse practitioner Ms G saw Mrs A for the first time following a referral from Dr H. Staff told her that Mrs A had been more aggressive and had been striking staff and residents. Ms G changed Mrs A's medications.[30] Ms G recalls that staff took responsibility for contacting Mrs A's family regarding the changes to her medication. Ms C understood that Ms G spoke with Mrs B each time she changed the medication. However, Mrs B said she was not contacted about changes to her mother's medications.

On 20 August, caregivers reported a bruise on Mrs A's right hip and that she was barely walking. Caregivers noted that Mrs A was increasingly refusing to have showers or undress.

On 21 August, a caregiver reported that Mrs A's lower dentures were missing. Four days later, Mrs A's lower dentures were noted as "still missing".

On 26 August, Ms G saw Mrs A. Staff reported that Mrs A had been more aggressive. Mrs A appeared alert but sleepy. Ms G conducted a physical examination and queried "possible dehydration secondary to diuretics". Ms G spoke to Dr H about holding the furosemide until laboratory tests were done.

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[25] A score sheet for determining a person's risk for falls.
[26] A short questionnaire to screen for and monitor cognitive impairment.
[27] A short questionnaire used to screen for depression in older adults.
[28] A score sheet used to determine a person's risk of developing pressure ulcers.
[29] Another score sheet used to determine a person's risk of falling.
[30] Her medications of half a risperidone 0.5mg tablet twice a day and methotrimeprazine 6.25mg at noon were changed to one risperidone 0.5mg tablet twice a day. Methotrimeprazine (Nozinan) is an antipsychotic and sedative drug and had been used to decrease Mrs A's delusions.

On 28 August, Dr H noted Mrs A's continuing perineal rash. Dr H noted, "hasn't had Lamisil — to chase from pharmacy" in the medical notes. However, terbinafine (Lamisil) was documented on the "PRN Medication Administration Record" from 15 August to 12 September, but was not recorded for 19 and 26 August and 10 and 11 September.

The next day, Mrs A complained of not being fully right. She was continuously agitated but denied any pain. Her heart sounded slightly irregular but her lungs were clear. Her pedal oedema had spread to both knees. Staff called Dr H for a nitrolingual spray after Mrs A complained of chest pain in the afternoon. She was reported as feeling unwell in the days following this episode.

Mrs A was also seen by Ms G. Ms G noted that Mrs A had a groin rash that was affecting her gait. Ms G noted that she and the nursing staff at Belhaven were concerned that Mrs A's agitation could be related to her hypoxia and cardiac status.

September 2008
On 2 September, Mrs A complained of being tired from walking. She was sleepy but also agitated and wandering. Ms D requested she continue to be monitored. On the same day Mrs A's groin rash was noted as "looking good not red at all". She was seen by Ms G, who found her asleep at a table in the Lodge. Ms G documented that the progress notes showed that Mrs A was very active in the afternoon and some nights. Mrs A was resisting care at times. Ms G decided to continue her current medications.

On the morning of 11 September, a caregiver reported that she had seen bruises on Mrs A's legs and arms. This was the last incident report completed for Mrs A. Ms C signed the incident report on 12 September and, on 22 September, noted, "Nil untoward."

On 12 September, the course of Lamisil was completed. Ms G noted that Mrs A's gait was slow, she was not using the walker well, and she was also being assisted by staff. She was alert and attentive but had poverty of thoughts.31

On 15 September the groin rash was noted as healing.

On 19 September, Ms G recorded that staff reported that Mrs A continued to be lethargic in the morning and agitated in the afternoon. Ms G reduced Mrs A's morning risperidone to 0.25mg. The rash under her breasts was looking red and her dentures were still missing. Ms C noted: "Dentures not found. Thorough search of the Lodge carried out." Ms C explained that:

> "it was not uncommon in the dementia unit for mobile residents to remove dentures, glasses, hearing aides, watches, rings, jewellery and to put them down

[31] Poverty of thoughts is a reduction in the quantity of thoughts a person appears to be having, and may be a feature of severe depression or dementia.

> where ever they were. A thorough search of the premises was always carried out before these items were deemed to be lost forever. For every resident putting down items there was another picking them up. Dentures could be found in another resident's mouth or glasses on another resident. They could also be found in bed linen on the bed or going through the laundry. Still others put things away in pockets, toilet bags, in drawers, under cushions, down the back of chairs … it was not a simple matter to find missing items and the vast majority were found."

Some time later Mrs B asked Ms C if there was a particular dentist that the rest home used. Mrs B considered that replacing the dentures would be an extremely difficult task for both the dentist and a patient with dementia. Mrs B clearly recalls that Ms C said, "They may turn up yet. But anyway it doesn't matter because [Mrs A] can still eat." Mrs B was more concerned about her mother's dignity. Ms C denied intimating that Mrs A need not have her dentures replaced. However, she cannot recall speaking to Mrs B about the dentures being still missing.

On 21 September, Mrs A was reported to be not feeling well and her legs were very sore.

On (Monday) 22 September, Ms G recorded in her clinical notes:

> "[Mrs A] was seen at Belhaven. She was just getting dressed after having a shower. She was alert and attentive. She was assisting in dressing herself. She made eye contact and talked some. She has pitting oedema of both legs. When I was checking the oedema she slapped me. Staff also report she slapped them when getting her up. [Mrs A] also slept until noon on Saturday.
>
> Physically — her lungs were clear and her heart RRR[32] abd soft.
>
> Last Friday, I reduced her Risperidone because of the increased sedation.
>
> She did sleep late on Saturday. Today she is feisty and slapping staff.
>
> Plan — I will monitor her behaviour with the reduction in Risperidone. It could be she might do better with an SSRI.[33] She is on 10 doxipen at bedtime.
>
> Review later this week."

Ms D recalls that on 25 September, between 10am and 11am, Mrs A:

> "was very mobile, chatty and smiling. She had no limp, did not appear to be in any pain and was not agitated at all."

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[32] Regular rate and rhythm.
[33] Selective Serotonin Reuptake Inhibitors are a group of antidepressant medications used in the treatment of depression, anxiety and personality disorders.

On 26 September, the day after Ms D finished working at Belhaven, Mrs A looked pale and was unresponsive. Ms C was called in to see her. Ms C noted that Mrs A had been hitting staff again and was "very lethargic to go to bed as unable to keep her eyes open". The same day, Ms G made a follow-up visit. Her report states:

> "Staff report [Mrs A] is starting to hit staff more often during cares. She was striking staff during her shower this morning. Currently she is sitting in a chair not interacting with staff. She has poverty of ideas. She has a flat affect. She does sleep ok some nights and does some wandering in the afternoon.
>
> I have increased and decreased her Risperidone recently for agitated behaviour and sedation. She is either too sedated or hitting staff.
>
> Plan — use an SSRI to see if this will reduce agitation
>
> Consider D-6 Placement."[34]

On 30 September, Ms C entered "apply cornflour under breast & groin" in the progress notes and Mrs A's care plan.

October 2008
On 1 October, Ms C noted that Mrs A continued to be lethargic. Ms G also noted that she was lethargic. Staff had documented that she had been cooperative and ambulatory the day before. Mrs B noticed that her mother's condition was deteriorating.

On the morning of 3 October, Mrs A's mobility was very slow and she was hardly walking.

On (Saturday) 4 October, a caregiver noted that Mrs A had bruises on both arms. No incident report was completed. Mrs A was noted as "mobility slow and very sleepy". On 5 October, a caregiver noted that she was "very frightened to walk".

On (Monday) 6 October, Mrs A was noted as very pale and not eating. Dr H ordered a number of blood tests, including: renal function, liver function, and blood count. On 7 October, Mrs A was noted as pale and eating little. A caregiver also noted that she had bruises on both hands. On 8 October, Mrs A was still pale and was given assistance with eating.

On 9 October, Dr H noted that Mrs A had a raised white blood cell count and had stayed in bed, sleeping. He noted that Mrs A's urine did not have an offensive smell

[34] D6 residents require hospital level dementia care and often have complex psycho-geriatric difficulties and require specialised psycho-geriatric care.

and her chest was clear. Dr H prescribed Augmentin[35] and noted that she probably needed hospital level care but did not refer Mrs A for a needs assessment.

Caregivers noted that Mrs A's walking, appetite and general health were getting worse.

On (Friday) 10 October, a caregiver noted that Mrs A was very shaky and found it hard to stand. A caregiver wrote in the progress notes "use lifting belt" when moving Mrs A. Ms C sent Ms G a text at 12.39pm, which read "[Mrs A] very flat, called in family. Can am Rispal be decreased. OK pm." Ms G had recently increased the risperidone prescription. She visited Belhaven while Mrs A was away on an outing, and referred Mrs A to the Needs Assessment/Service Coordination (NASC) service. Ms G recorded that Mrs A was becoming more dependent on staff, needed two people for transfers, and sometimes required help with feeding. Staff commented that Mrs A had not got up the previous day. Ms G rang and left a message for Mrs B about transferring Mrs A to hospital level care.

On 12 October, caregivers noted that Mrs A was very tired and hard to understand. The next day, Mrs A appeared very tired and reported being sore when moved. She could not swallow much or move any part of her body. Caregivers asked Ms C to examine Mrs A after she collapsed in the shower. Ms C later stated that Mrs A's skin was fine with no wounds or marks on her heels. Ms C noted that she "looks exhausted rather than cerebral event".[36] Ms C phoned the family and Mrs B arrived within 10 minutes. Mrs B observed that her mother appeared very unwell and was not talking. Mrs A was dressed and in bed when Mrs B arrived, so she was unable to observe the condition of her mother's skin.

Ms G left a message for Ms C, which included that caregivers were to turn Mrs A every two hours, withhold that night's risperidone and the following morning's furosemide, risperidone and Span-K, and give liquid paracetamol. Caregivers recorded in the progress notes that Mrs A was not moving. Ms G had discussed this with Dr H. It is not clear from the medication administration record if any of these instructions were followed, apart from the risperidone being partially withheld. Liquid paracetamol was not recorded on the PRN Medication Administration Record until 15 October.

In the evening, a caregiver noted that every time Mrs A moved she said she was sore. Mrs A was checked hourly and given a drink. That night, Mrs A could not move any part of her body.

On 14 October, Mrs A ate breakfast well and was checked by Ms C in the shower. Ms C later stated that Mrs A "had peri anal redness with 3 or 4 labial and buttock cuts of unknown origin, not wide enough to be scratches". Ms C did not observe any marks

[35] An antibiotic.
[36] Cerebral event presumably refers to a stroke.

on Mrs A's heels. Later that day Mrs A's rash in her groin area was very red and there was a skin tear right through to her buttocks, which was bleeding. Mrs A's "bowels were very runny". A caregiver wrote in the progress notes that Ms C was informed but Ms C made no comments in the progress notes and did not develop a wound care plan. That afternoon, Mrs A developed diarrhoea.

On 15 October, Mrs B, Ms G and a needs assessor met at Belhaven to discuss the need for Mrs A to be transferred to hospital level care. Mrs B noted that her mother was extremely unwell. Mrs A was not responsive and her body was twitching. Mrs B believed that her mother was either in pain or very uncomfortable. Mrs B observed that her mother frequently grimaced and was squirming as though she was trying to get comfortable. Ms C noted that Mrs A was not very responsive but moaned with pain when moved. Ms G recorded that staff told her that Mrs A had been eating and drinking some but she hadn't been out of bed. Staff also reported that Mrs A had not been moving at all at night. Ms G informed Mrs B that Mrs A might be dying.

Ms G reviewed Mrs A's medications and decided to hold her noon furosemide as well as her morning dose, stop her risperidone, and give liquid Panadol. Ms G also told staff to turn Mrs A every two hours.

Ms C commented:

> "[Mrs A's] medications had been altered over at least the last 2–3 weeks and she was either aggressive or quiet depending on the medication changes but had not become bedridden or unable to walk. [Ms G] kept in contact with [Mrs B] as she was making changes to find an acceptable combination of drugs for [Mrs A] … There was no declining health or wellbeing there was changes to her medication for her aggression."

That evening, a caregiver recorded in the progress notes that cornflour had been applied to Mrs A's groin and that she was to be turned every two hours during the night as per Ms G's instructions in the day book. Mrs A had loose bowel motions all through the night.

On 16 October, a skin tear was noted on Mrs A's left hip. Mrs A was transferred to a private hospital. On arrival she was assessed and photographs were taken of large black blisters on each heel, serious skin excoriation around her vulval and perineal areas through to the buttocks, and broken skin on her left hip. The manager at the private hospital phoned Mrs B for permission to take the photographs. This was the first time Mrs B was aware of any concerns about her mother's skin integrity. Ms G visited Mrs A a couple of hours after her arrival. She viewed Mrs A's heels and groin. She noted that Mrs A had a severe groin rash and black necrotic areas of both heels. Ms G believes the groin rash was likely to be fungal and the heels were the result of inadequate turning.

Mrs A continued to have loose bowel motions and impaction[37] was queried as a possible cause.

A few days later, Mrs A died.

Communication with family
Mrs B wrote to HDC on 8 June 2009 complaining that she had received only two phone calls about her mother's health. The latest was on 13 October 2008. In the period under investigation, Mrs B considered that she should have been contacted when her mother had a large bruise on her face, when her dentures were lost, and in the last two to three weeks when her mother was "no longer able to walk".

During the period under investigation, Dr H conducted two three-monthly reviews of Mrs A. The first was on 22 May 2008, and the second was on 14 August 2008. Ms D stated:

> "My standard practice was to ring the family prior to three monthly reviews, to invite them to attend or to express any concerns, but I have no records of this to confirm it was done. My recollection is that no family attended the three monthly review."

Mrs B said that she first saw Ms D's name in a letter from the needs assessor dated 18 November 2008. While she may have met Ms D at Belhaven, she does not recall being introduced to her as the registered nurse. Neither Mr E nor Mr F recall meeting Ms D. Mrs B and her two brothers stated that they were never contacted regarding Mrs A's care plan, and were unaware of the three-monthly review meetings.

Mrs B most often visited her mother in the afternoon after work or before starting an afternoon shift. Ms D had normally finished work by this time. However, Mrs B said she had demonstrated that she was willing to visit the home at short notice when called. Ms D stated that she sometimes worked after her normal hours to meet with family members.

Ms D recalls that she may have spoken to a member of Mrs A's family after Mrs A had an altercation with another resident. She remembers speaking to the family member in the hallway of the Lodge about taking Mrs A back to the doctor after the altercation, but could not recall whether she had spoken to Mrs B or one of her brothers. Neither Mrs B nor her two brothers recall this incident. An incident form completed on 7 August describes an altercation with another resident. On 12 August, Ms D wrote on the form, "Request staff get MSU[38] & check bowels and talk to GP about new aggression." There is nothing recorded about speaking to the family.

[37] Impaction: the presence of a large or hard faecal mass in the rectum or colon.
[38] Mid-stream urine for testing.

Following Mrs A's death, Mrs B received an invoice for consumables (hair care, etc) with a note of condolence typewritten on the bottom of the invoice. Mrs B viewed this as insensitive. Ms C stated: "I believe if I hadn't recorded my condolences following the death of [Mrs A] the complaint from [Mrs B] would have been that I was unfeeling in not recognizing her death." Mrs B would have appreciated a phone call from Belhaven following her mother's death.

Mr E recalls Ms C being very abrupt, whereas Ms J was approachable. If he had any questions he would speak to either Ms D or Mr K. They never discussed anything about his mother's clinical care. Mr F does not recall meeting Ms C.

Further issues identified during investigation

Documentation

Belhaven was unable to produce a number of documents requested as part of the investigation. Some of these documents either never existed or have subsequently been lost, despite multiple searches. One of the missing documents is the "Lodge" diary (communication book) for the 2008 year. Both Ms D and Ms C advised that many of their instructions to caregivers and notes of communication with family members were written in this book, and were not always written into the care plans or progress notes. Many of Ms G's visits were not recorded, despite it being a requirement in the Aged Related Residential Care Agreement that the rest home ensure that visits by general practitioners or other health professionals are entered into the relevant clinical records.

Other documents not able to be supplied included:

- signed job descriptions for Ms C and Ms D
- an up-to-date care plan for Mrs A
- any wound care plans for Mrs A
- bowel, fluid balance and food intake records for Mrs A
- specimen signature sheets for the period under investigation.

Both Ms D and Ms C stated that when they started working at Belhaven, the documentation was disorganised and out of date. Ms D recalls that:

> "the nursing care plan for [Mrs A] was one of the better ones. Many of the other patients' files were out of date and incomplete. Some of the residents had been there for three or four months and yet there was no documentation … There were lots of irrelevant paperwork filling the drawers."

Ms C recalls that:

> "the policies and procedures were on the computer but were not well organised in logically ordered folders. Similarly with the audits. They were fragmented and therefore difficult to use. Finding relevant documents was time consuming and frustrating."

In relation to the "Lodge" diary, Ms D commented that she "used to write in the diary as it was difficult to communicate with staff and staff didn't read the notes". Ms D said that she wrote in the diary, "do not let [Mrs A] wear pads during the day", and "make sure you take [Mrs A] to the toilet". In retrospect, Ms D wishes she had also written this in Mrs A's progress notes.

Belhaven stated that its policies and procedures were completely replaced by Ms C during her employment.

Care plans
Belhaven's Care Plan policy (dated 3 April 2008) states:

> "The nursing care plan and progress notes are reviewed by a registered nurse who also consults with resident/relative/agent at each evaluation … Nursing staff are expected to inform the Registered Nurse or management if they feel that a care plan is not up to date or they feel the resident's need of care has changed. Each care plan is evaluated, reviewed and amended either when clinically indicated by a change in the resident's condition or at least every six months."

Mrs A's care plan was last reviewed on 14 November 2007 by the previous registered nurse. Mrs B was not consulted by the previous registered nurse. No subsequent care plans were found in Mrs A's file or on Belhaven's computer.

Ms D stated that when Ms C started at Belhaven she said she wanted the nursing care plans to be the way she preferred and she was going to take them all and redo them.

On 10 September 2009, Ms C explained that the care plans were the first thing she wanted to change, as they were hard to read. They had a format that required a nurse to circle relevant pieces of information, which meant that a page would have a lot of irrelevant (not circled) information. She preferred a format that had only relevant information on the plan.

Ms C's lawyer advised:

> "Our client had recorded in a diary the reviews for the year and had explained to [Ms D] when they were due."

A copy of the diary has not been provided.

In relation to Mrs A's care plan, Ms C's lawyer commented:

> "Our client's only involvement with the care plans was an administrative function, converting them into an electronic format. … It was practice within the home for the Registered Nurse to review the files on a 3 monthly basis."

Incident reporting
Ms D commented that there were more altercations than those reported in the incident forms. She was surprised that there were not more incident forms, as she would tell staff to "fill out an incident form if [Mrs A] hit them". Ms D stated that "[Mrs A]

didn't like to be rushed", and "[Mrs A] had a large personal space". During the period under investigation, at least 17 incidents were identified from Mrs A's progress notes that should have been reported but were not.

Nutrition and weight loss

Mrs A lost a significant amount of weight in the second half of 2008. On 18 May 2006, Mrs A's weight was recorded as 53kg. It rose to 63kg on 29 May 2007 and was relatively stable for six months until 1 January 2008, when it was 60kg. No weights were recorded between then and April 2008. On 27 May and 3 July, Mrs A's weight was 60kg. Her weight then declined to 58kg in August, 54kg on 25 September, and 50kg on 5 October 2008.

Mrs A was reported as refusing to eat on 2 June 2008 and 29 June. In July, Mrs A occasionally refused to eat and, on 27 July, Fortisip[39] was recorded as being given. On 8 August, a caregiver noted that Mrs A needed assistance with meals. In September, caregivers reported more episodes of Mrs A refusing to eat, or eating less. On 5 October, a caregiver recorded in the progress notes that Mrs A had lost 4kg. Ms D recalls that Mrs A was being given Fortisip, but Ms C could not recall whether Mrs A was having Fortisip. No prescription for Fortisip for Mrs A has been provided.

Ms D recalls that a caregiver had told her that Mrs A took longer to eat than other residents, and that staff may have been taking away Mrs A's meals before she was finished. However, Ms D used meal times to catch up on her paperwork and so was not routinely supervising staff and residents at meal times.

Ms C had introduced monthly Body Mass Indexes (BMIs)[40] when she started at Belhaven. The caregivers weighed the residents and the results were entered into the computer. At the end of the year each resident had a graph of his or her BMI. In the meantime the data was entered into a spreadsheet. Ms C advised HDC that if a resident's weight did not go outside the normal range, she would not take any notice. Belhaven was not able to supply the spreadsheet. On 22 May 2008, Dr H noted that Mrs A's BMI was 26.

Medication management

The medication signing sheets generally confirm that prescribed oral medications were given, although there is some confusion about medication around 14 October 2008. However, when paracetamol was inserted into the blister packs rather than being provided as needed, Mrs A's care plan was not updated. There is no documented evidence that this change was evaluated.

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[39] A nutritional supplement.

[40] BMI is calculated by dividing a person's weight in kilograms by the square of their height in meters. A BMI between 18.5 and 24.9 is considered a healthy weight for an adult. A BMI below 18.5 is unconsidered underweight. BMIs are not recommended for use with older people, who tend to lose muscle mass. Some studies suggest using a BMI between 25 and 27 as normal for older people (see Z. Cook, S. Kirk, S. Lawrenson and S. Sanford, "Use of BMI in the assessment of undernutrition in older subjects: reflecting on practice". Proceedings of the Nutrition Society (2005), 64, 313–317.

On 19 May 2008, a caregiver reported to Ms C that Mrs A's furosemide tablet had not been given, although it had been signed for. Ms D followed up the incident and, on 28 May 2008, wrote on the incident form, "Staff have been spoken to and this will also go to the staff meeting to re-do medication competency."

Some time on or after 26 May 2008, someone (change not signed) wrote on Mrs A's medication chart an instruction to "crush tablets". The next medication chart, from 15 August 2008, contains the same instruction (change again unsigned). The final medication chart from 19 September 2008 does not contain the instruction.

On 23 May 2008, Nozinan (methotrimeprazine) was prescribed and, shortly afterwards, Mrs A's first aggressive episode was reported. On 26 September, Citalopram[41] was prescribed. There is no evidence that Ms D or Ms C recorded any positive or negative side effects of these medications and reported them to the prescriber.

On 21 July 2008, a caregiver again reported to Ms C that Mrs A's furosemide had not been given for two days. No follow-up action was recorded.

On 9 October 2008, Augmentin was prescribed by Dr H at 1pm. The first row of the "Non Packaged Medication Administration Record" for the Augmentin is dated 10 October 2008. The record shows entries for "am", "lunch" and "tea". An entry was made above this in the header line of the record for "tea" on 9 October 2008. There is an undated and unspecified entry on the PRN Medication Administration Record at 0600hrs by the same caregiver who added the entry for 9 October 2008. Next to this is an instruction to "[t]ransfer to non packaged medication administration record???".

In response to my provisional decision, Ms C's lawyer stated that on the night in question:

> "the medication was delivered to Belhaven by the pharmacy between 5.30pm and 6.00pm. By that time, our client had left for the day and was unable to administer it to [Mrs A]."

Mrs A was taking Tamoxifen for her breast cancer. Tamoxifen has a number of adverse side effects, including affecting the cardiovascular, metabolic and central nervous systems. There is no evidence that the potential side effects were monitored.

Mrs A was routinely given laxatives, despite having loose bowel motions on numerous occasions, and diarrhoea in her last days at Belhaven.

Medications prescribed by the GP in the medical progress notes were not always added to the medication prescribing chart.

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[41] Citalopram (brand name Celapram) is an antidepressant drug used to treat major depression associated with mood disorders.

The administration of topical medications was not routinely recorded, despite the requirements of Belhaven's Staff Medication Competency Checklist.[42]

Ms D stated:

> "I was frustrated and at times felt professionally unsafe over things like constant shifting of staff, lack of activities for residents and staff whose lack of comprehension of English led to medication errors, treatment not being done, medication not being started when charted. I felt I had to ring to ensure medication and treatments had been administered appropriately … I often expressed to the directors my concerns about the lack of understanding of the care workers with poor English … After a considerable amount of incident reports on one carer they finally agreed she should no longer give medication … Many times antibiotics that arrived in the evening I would come the next morning to find drugs not started despite having left clear instructions and ringing in the evening."

Ms C's perception of the caregivers was that:

> "they would bend over backwards to care for the residents. There were a lot of Filopinos and language was always a problem. They would always tell you what they think you want to hear, but for hands on care they were excellent."

Ms J stated that:

> "the previous manager to [Ms C] had hired a few Filopinos … [I] was aware that their English was not great but was not aware that a staff member had been asked to translate instructions to another staff member because of language difficulties."

Staff orientation and training

Both Ms D and Ms C stated that when they started at Belhaven they were given a tour of the facility and were instructed on health and safety procedures for the facility. Neither were put through Belhaven's staff orientation programme.[43] Ms D stated that staff did have an orientation programme when they started work if there was someone to do it.

The contract with the DHB required Belhaven to ensure that:

[42] The checklist includes requiring staff to "[c]heck PRN/Topical meds given at this time." and "[r]ecord medication administration by noting time, date and signature".

[43] Belhaven provided a copy of its staff induction/orientation programme, including: the information provided to new staff, the checklist for training a staff member on his or her first two days, an orientation signing sheet with 36 items to have been read or shown, and a staff medication competency checklist. Staff are required to be buddied for their first two shifts and attend an orientation session within six weeks of starting.

> "all staff assigned to work in the [dementia] Unit receive a planned orientation programme specific to their area of service. This shall include a session on how to implement activities and therapies."

Belhaven was also required to ensure that caregivers working in the dementia unit had achieved or were studying towards a number of appropriate unit standards.

Ms D stated:

> "I felt that the level of care provided by some staff was poor, and [I] could not find any evidence that they had undergone training. Some staff used the diary to write clinical notes. I believe this happened because of a lack of education and understanding. … I believe [the directors'] lack of a health education background hindered their ability to see potential health risks for residents and their focus did not always appear to be in the best interest of the resident."

Ms C ran monthly educational meetings, but Ms D often couldn't get to them or was called out of them.

Ms D advised that she informally supervised staff. She stated that when she resigned:

> "I did so because it was clear [Ms C] and I could not work as a team, and there was a lack of support from all the management of Belhaven. I was frustrated and at times felt professionally unsafe over things like constant shifting of staff, lack of activities for residents and staff whose lack of comprehension of English led to medication errors, treatment not being done, medication not being started when charted. I felt I had to ring to ensure medication and treatments had been administered appropriately."

Neither Ms D nor Ms C had a formal performance appraisal. Belhaven's Staff Orientation policy was for an initial appraisal to be done at 11 weeks, another to be done at six months, and thereafter annually. The job description for the manager position provided by Belhaven stated that the manager's performance appraisal would be "carried out three months after commencement of the position and thereafter annually by the Directors".

Follow-up actions

DHB audit

Late in 2008 and early 2009, the DHB received multiple complaints concerning Belhaven, including two from Ms D following her resignation from Belhaven (one following Mrs A's death and another in December 2008 relaying concerns from caregivers working at Belhaven), and one from Mrs B dated 1 February 2009. The DHB commissioned an issues-based audit. A site visit was conducted on 23 and 24 March 2009. The audit found a number of service areas where moderate priority corrective action was required, including:

- care plans
- care documentation

- short-term care plans
- progress notes
- access to specialist services
- availability of sufficient staff
- registered nurse requirements
- manager's qualification requirements
- manager ensures that residents' needs are met
- education of all direct care staff within six months relevant to needs of residents
- competencies are monitored
- protocols for support/advice to on-duty staff.

The audit confirmed that communication with family was often noted in the communication book but not in an individual resident's file. Care plans were out of date, and no family involvement was documented.

The audit made a number of recommendations, including:

- ensuring that all relevant information is held in the individual resident's folder, including progress notes and communication with family
- staff to be given additional skills and strategies to manage residents with confusion and restlessness
- prompt quality improvement processes when events or problems cannot be adequately managed
- care plans will be specific for each individual's needs
- short-term care plans are developed as appropriate and instructions on personal and clinical care will not be entered into the progress notes or communication book
- staff to document care and monitoring in the progress notes every shift
- shift handovers and access to care plans to be made more user friendly
- three-monthly medication reviews to be adequately documented
- updated job descriptions for the managers and registered nurse will be developed
- schedule of staff training to be developed covering all care staff
- staff providing wound care will be first trained and assessed as competent
- develop an on-call policy for the registered nurse to support on-duty staff.

Ms D
Ms D has acknowledged that there were shortcomings in the care she provided to Mrs A, and she has initiated various measures to address them. Ms D stated that she would be more assertive in following through on treatment decisions following assessment of her patients. In hindsight, Ms D regrets not doing the care plans herself.

In response to my provisional decision, Ms D advised:

"Since leaving Belhaven I have:

- Completed at my own cost a DDA auditor training programme, which was a week's duration and has given me an absolute fresh, encouraging and clear

understanding about documentation and the need to have it connected to ensure that patients' care is paramount;
- I have retained a personal supervisor over the last six months to assist me on the proper procedures relating to documentation, development of documentation systems and implementation;
- In November 2009 I undertook a course on workplace bullying, which has enabled me to have some confidence that I will be better able to deal with situations such as I faced at Belhaven, whilst remaining completely professional."

Ms D commented:

> "I acknowledge my shortcomings in certain aspects of my professional responsibilities and have taken action to address those. I have determined that I would never put myself in such a vulnerable professional position again. I am extremely sorry about the deterioration in [Mrs A's] care and the outcome that resulted.
>
> I believe I stretched myself too thin trying to fill all the gaps at Belhaven and I acknowledge that my record keeping suffered as a result. That responsibility I accept as mine. With less than adequate staffing resource and undertrained staff I feel, however, that the Belhaven workplace was not a supportive environment professionally and this contributed to a less than adequate environment for patient care."

Ms C
Ms C stated that she has made no changes to her practice as a result of Mrs B's complaint.

Belhaven Rest Home Ltd
Belhaven has confirmed that it has actioned all of the requirements of the DHB audit. Belhaven has employed a registered nurse and an enrolled nurse. Belhaven now takes photographs of wounds to assist in wound management. Each day the nursing staff check the communication book for any changes and then check the relevant resident's notes. The nurses check each resident's notes at least once a week.

The directors now have a more active role in the management of Belhaven, which is specified in their job descriptions. The directors now sign off any changes to policies and procedures. Belhaven commented:

> "The Directors acknowledge our error in trusting the residents of Belhaven and its day to day running entirely to someone else. As a result of this Belhaven has changed its complete operation in an effort to prevent anything of this nature occurring again. We have employed a new nursing team. [I] have taken the responsibility of Manager. I am now more involved in the medical conditions of the residents, the nursing team keep me well informed I sight all wounds, despite my non medical background I can at least say that I am aware of what is happening with the Residents of Belhaven."

Belhaven has apologised to Mrs B and met with her regarding the changes that have been put in place to improve standards of care.

Response to provisional opinion

Mrs B, Ms D, Ms C and Belhaven all clarified several matters, which have been incorporated into the "information gathered" section of my report.

Ms D
In response to my provisional decision, Ms D also commented:

> "[Ms C] made the management decision that she would get all nursing care plans up to date and that my responsibility was to deal with day to day care of patients, doctors' records and assessments. In hindsight, I should have written the nursing care plans myself. Assessment of patients was something I saw as part of my job description.
>
> …
>
> The Registered Nurse position description may have stated what my duties were, however my direct supervisor amended those on a day to day basis.
>
> …
>
> From these experiences, I now understand that Belhaven had a system of record keeping which had been developed over time, which in hindsight was clearly inappropriate for such an operation. It did however meet the needs of the staff and had the support of both the nurse manager and the owners. In such circumstances, I suggest that it would have been difficult for me alone to have required change to that process.
>
> …
>
> It is unfortunate that the chaos in the administration area of the Belhaven business reflects on me.
>
> …
>
> I do not believe that sufficient weight has been attached to the nature of the part time position which I undertook. I was working under the direct supervision of a Registered Nurse, [Ms C] who advised me she was taking responsibility for the nursing care plans. Whilst I acknowledge that there was a shared care arrangement in relation to [Mrs A], under the employment situation it is difficult to challenge the direct decision of your immediate supervisor. My contribution to the nursing care plans were the assessments that [Ms C] required me to undertake.

…

I had taken advice from the local pharmacy as to how the medications could be taken by dementia patients in particular when they would not take the medication without changing the initial structure of the drug. Of course there is no evidence of this, given that any instruction I gave for the application of medication to the staff or notes on medicine results were entered into the Lodge diary. … Accordingly it is impossible for me to provide evidence of how I evaluated the responses to new medication, or how changes to medication were recorded."

Ms C

In relation to Mrs A's state of health, Ms C's lawyer commented:

"There is no evidence to show our client failed to appreciate [Mrs A's] condition. She was constantly aware of her state of health and maintained regular consultation with the Nurse Practitioner who prescribed the medication."

In relation to Mrs A's weight loss, Ms C's lawyer stated:

"[Mrs A's] weight was monitored monthly and at all times her weight was in the healthy range. Staff made notes on several occasions that [Mrs A] was having some issues with food intake. All issues were monitored appropriately and care was made to ensure [Mrs A] remained within the healthy range.

[Mrs A's] eating was also affected by the medication she was taking to deal with her aggression.

Staff often recorded food intake in the communication book which helped monitoring of these issues."

In respect of staff training, Ms C's lawyer advised:

"The report has suggested that [Ms C] had a responsibility to ensure staff were aware of side-effects and medication errors.

This was a responsibility of [Ms D] in the time that she was Registered Nurse. In the time our client was at Belhaven, she ensured that there was one annual planned training as per best practice.

As for medication errors, individual staff would follow up on these. There were no errors noted in [Mrs A's] individual staff files."

In relation to use of laxatives, Ms C's lawyer stated:

> "We are advised faecal impactions were only mentioned by [the private hospital] as a possible cause of loose motions. Bowel records showed regular bowel movements or laxatives given."[44]

In terms of the bruising and discoloration underneath Mrs A's heels, Ms C's lawyer advised:

> "From our discussions with medical professionals specialising in the area of elderly care, it has come to our attention that it is not uncommon for skin discoloration and bruising to occur rapidly as it did on this occasion. … There is a suggestion that these ulcers would have developed once [Mrs A] stopped moving. … [Ms C] did advise the staff verbally to turn her. The staff reported that [Mrs A] would turn onto her back, and they would move her back onto her side. The staff also put a pillow under the mattress to adjust [Mrs A's] position."

In relation to Mrs A's groin rash, Ms C's lawyer stated:

> "[Ms D] carried the responsibility as Registered Nurse for the majority of the time that the rash was present.
>
> …
>
> From the evidence it is clear to see that there were ongoing problems with the rash. Amongst various other treatments, our client requested staff to apply cornflour to the rash. In the 45 years our client has practiced as a nurse she has seen this work for the treatment of excoriation. … Note should be made that there were several attempts to treat the rash with various medications and treatments and this was not the sole treatment provided.
>
> …
>
> Our client provided verbal instructions to care staff regarding the increasing care need at that time. These were not written instructions, however the fact they were verbal does not take away from the fact they were given. Caregivers recorded that they carried out their instructions."

In summary, Ms C's lawyer commented:

> "If attention is focussed only on the last period of [Mrs A's] life then the criticism needs to be moved to Belhaven, not our client. It is for the Rest home to ensure they are adequately staffed and appropriate resources are provided. We note that our client was hired as Nurse Manager, not Registered Nurse. Her position was in the office and involved day-to-day management tasks varied from that of the Registered Nurse. This is evidenced by the fact [Ms D] was working at the home as

[44] No bowel records have been provided to HDC beyond entries in the progress notes.

Registered Nurse at the same time our client was Nurse Manager. This indicates that there were two separate jobs, both requiring full-time positions.

When [Ms D] left, the duty was then on Belhaven to ensure a Registered Nurse was hired to replace her. Belhaven failed to do so, and instead required our client to perform two functions with no additional resource of time or remuneration. Any observed lack of care in regards to the services being provided by the home in this period should be focussed on Belhaven, not our client.

Our client has advised that she believes in her work and believes she treated [Mrs A] with a high level of care."

Relevant standards

The relevant standards are attached as **Appendix D**.

Opinion

Overview
Belhaven Rest Home and its staff had a duty of care to Mrs A. Mrs A's general condition appeared to be relatively stable between April and July 2008, but there were health issues reported in August and September. From 21 September, caregivers reported increasing health problems. On 9 October 2008, Dr H diagnosed an infection and Mrs A's health deteriorated markedly from then on. She also lost a substantial amount of weight.

In my view, Belhaven and its staff failed to act appropriately and promptly in response to Mrs A's deteriorating condition. The investigation has highlighted significant lapses in the care provided to Mrs A. I agree with aged care expert advisor Noeline Whitehead that Ms C, Ms D and the rest home must share responsibility for this.

Breach — Ms D

Under Belhaven's Aged Residential Care Agreement, as a registered nurse at the rest home from 31 March 2008 to 25 September 2008, Ms D was responsible for working with staff and Ms C to:

- assess residents
- develop and review care plans with residents and their families

- advise on care and administration of medication
- provide and supervise care
- educate staff
- monitor the competence of staff
- advise management of staff training needs
- assist in the development of policies and procedures.

I accept that Ms D was not given a job description, and that her role was prescribed by her manager, Ms C.

Nonetheless, Mrs A's nursing needs were numerous because of her age, medical history and dementia. In my view, Ms D did not provide Mrs A with appropriate care and skill in the following areas:

Assessment, care plans and evaluation of care
Although Ms C took responsibility for updating the care plans, Ms D was responsible for ensuring that assessments and care planning were done and up to date. Furthermore, Belhaven's Care Plan policy required nursing staff to "inform the Registered Nurse or management if they feel a care plan is not up to date or they feel the resident's need of care has changed".

During the period under investigation, Mrs A presented with a number of problems (loose bowel motions, pain, mood swings, weight loss, skin integrity, tiredness, feeling unwell, and declining mobility and function). As my advisor noted, there is no evidence in assessments or care plans to indicate that these problems were identified and appropriately addressed.

Ms Whitehead advised that Ms D "failed to ensure adequate, ongoing assessments, reviews and updating of care plans and evaluation of care". In early August 2008, Ms D completed assessments for Ms C and placed them in Mrs A's file for Ms C to review. Mrs A's care plan was not reviewed and updated. It was last reviewed in November 2007. Ms D has subsequently acknowledged to HDC that she should have done the nursing care plans herself. She has apologised that Mrs A's care plan did not get done. While I acknowledge that Ms C took responsibility for writing the care plans, Ms D should have checked whether Mrs A's care plan was up to date and taken steps if it was not. There is no evidence that Ms D documented in Mrs A's file any evaluation of the care being provided.

Nutrition and weight loss
No evidence has been provided that Mrs A was weighed monthly, and there was no change to Mrs A's care plan when caregivers began reporting that Mrs A was not eating as well, or after she lost her dentures. Mrs A was being given a nutritional supplement, but there is no documentation regarding when and why this was introduced and how often it was provided. Ms D stated that at the time she was not too concerned about Mrs A's weight loss. However, Ms Whitehead stated:

> "[Mrs A] was on a number of medications known to affect appetite/cause nausea. In addition pain was likely to have affected her appetite."

Mrs A's nutrition was not well managed. While weight loss frequently occurs as a person enters the end stage of dementia, it should be closely monitored and responded to. There is no evidence of a comprehensive nutritional assessment or even nutrition and fluids chart being done when Mrs A was losing weight and caregivers were reporting issues to Ms D. It may have been appropriate to refer Mrs A to a dietitian.

In May 2007, Mrs A weighed 63kg. In October 2008, she weighed just 50kg, having apparently lost 10kg in the three months since July. I acknowledge that Ms D left Belhaven at the end of September; however, as my advisor pointed out, the failure of Ms D to "assess, review and update the care plan at the beginning of August when a small weight loss was identified may have contributed to the significant weight loss during August and September 2008". I consider that Ms D did not fulfil her responsibility and ensure that Mrs A's nutrition was managed adequately.

Mobility
On 8 August 2008, Mrs A's mobility was assessed and her care plan did not require changing. However, her mobility clearly deteriorated after 29 August.

Ms D contacted Ms G on a number of occasions to review Mrs A but no documentation has been provided as to the rationale for contacting Ms G, and no changes were subsequently made to Mrs A's care plan.

I agree with my advisor's view that "[Ms D] failed to ensure there was ongoing assessment, care planning and evaluation of [Mrs A's] personal care needs and mobility", despite an obvious decline in her mobilisation generally.

Mood swings/behaviour management
From 15 August 2008, Ms G was consulted regarding Mrs A's aggressive behaviour and sleepiness. Ms G adjusted Mrs A's medication. Ms Whitehead advised that as the registered nurse Ms D should have been identifying and documenting the triggers of Mrs A's aggressive behaviour. Ms D should have reviewed and updated Mrs A's care plan in June 2008, when Mrs A's behaviour became a problem.

Ms D was aware of some of Mrs A's triggers, including her needing a large personal space and not liking to be rushed, and handled these appropriately when present. However, by not documenting this information the knowledge was lost to Mrs A's caregivers. They needed guidance from the registered nurse on how to handle the situation.

It is particularly concerning that so many incidents recorded in the progress notes were not properly reported and followed up. While Ms D told care staff to report these, she should have also followed this up, particularly when incidents kept occurring.

Pain management
Ms D also had a responsibility to assess and review Mrs A's pain management and refer her to the GP if appropriate. In Ms Whitehead's opinion, some of Mrs A's behaviour could have been related to her pain. As Mrs A had breast cancer, she should have been monitored closely for pain. The pain may have affected her ability to walk. Ms Whitehead could not determine from the "substandard" documentation available whether Mrs A's pain was appropriately managed.

Communication with family
Ms D does not recall any communication with Mrs B, and none is documented. Although Mrs B often visited her mother in the afternoon when Ms D had gone, she had shown she was willing to visit at other times at short notice when called. Also, Ms D sometimes worked after hours to meet family members. She could not explain why she did not meet with Mrs B.

There appears to have been some confusion at Belhaven as to who was responsible for communicating with Mrs A's family. Ms D stated that she did communicate with the families of some of the other residents. Ms D also stated that forms for incidents that occurred after hours were put on Ms C's desk. The registered nurse job description provided by Belhaven did not specify communication with family members. Belhaven's Care Plans policy required that "[t]he nursing care plan and progress notes are reviewed by a registered nurse who also consults with resident/relative/agent at each evaluation". Clearly this did not happen. Ms G recalls nursing staff taking responsibility for contacting Mrs A's family, whereas Ms C believes Ms G was doing this. As Ms D was working closely with Ms G and Dr H, she should have raised the issue with Ms C and clarified who would contact Mrs A's family. In particular, the family should have been informed about Dr H and Ms G's visits and any changes to Mrs A's medications.

Skin integrity
Belhaven's wound management procedures specify that skin problems will have a care plan, and the registered nurse will follow up and sign off when the wound has healed. There is evidence that Mrs A's skin rashes were being treated. The GP was consulted by Ms D, and the skin rashes resolved for periods of time. I also accept that the subsequent pressure sores are likely to have developed after Ms D left Belhaven. Nonetheless, there is no documented evidence that Mrs A's skin rashes had ongoing assessment, care planning and evaluation when they failed to be completely resolved. The care appears to have been reactive despite the repeated nature of the problems. I acknowledge that some of the ongoing care may have been documented in the Lodge diary, but it would have been more appropriate to document this in Mrs A's file.

Management of Mrs A's medications
Mrs A was receiving a number of medications. These required careful management and regular review. Ms Whitehead identified a number of issues with Mrs A's medication management, including:

> "The crushing of medications that should be taken whole was an unsafe practice. It was [Ms D's] responsibility to provide advice on the administration of medication

> ensuring that care staff had an understanding of the side effects of the medications administered. Nor did [Ms D] provide evidence that she evaluated the response to new or changes to medications. Medications prescribed by the GP in the medical progress notes were not always prescribed on the medication prescribing chart. Laxatives were being given but they were not prescribed on the medication prescribing chart by the GP."

Ms Whitehead advised that Ms D's peers would regard her failure to ensure that the medication management met the required standard with severe disapproval.

In response to my provisional decision, Ms D advised that she had taken advice from a pharmacist about how medications could be given to dementia patients, and she had recorded instructions to staff in the Lodge diary, which subsequently went missing.

Even if this was done, my view is that there were serious deficiencies in the administration and management of Mrs A's medication, for which Ms D was largely responsible until she resigned. It is the registered nurse's responsibility to oversee medications, note any changes in patients, and report these to the doctor. Mrs A's mood swings and behaviour should have prompted further investigation to ascertain whether the medications were effective, and issues should have been reported to the GP and/or nurse practitioner. I acknowledge that Ms G and Dr H were consulted on a number of occasions, and Ms D reported staff problems with medication administration to the directors. However, she did not document her own observations and evaluations in Mrs A's file, or directly address the practices of care staff.

Documentation

Health professionals are required to document accurately and fully a resident's observations, progress, and the findings from any clinical examinations. Clinical records should be integrated, and therefore documenting clinical information outside the clinical record (eg, in a communication book) is not good practice. Ms Whitehead commented that Ms D's peers would expect:

> "the communication in the clinical record to tell the whole story about [Mrs A's] care, show her observations and how she acted on them, show continuity of care, show care delivered following her observations and show how [Mrs A] responded to care and medications and other treatments".

There appear to be no entries in the progress notes by Ms D, nor is there any indication that she regularly read or reviewed the progress notes. Belhaven's procedure for the progress notes stated that "the RN shall follow up on any documentation".

When Ms D was working part time, it was even more important for her to document her observations so that other staff had knowledge of any changes she had observed, and care staff were given clear guidance.

Ms Whitehead also noted the numerous incidents in the progress notes that were not documented on incident forms, and the lack of evidence that these were investigated and appropriately followed up by Ms D or Ms C.

Ms Whitehead advised that other nurses would view Ms D's conduct in relation to documentation with severe disapproval.

I accept that Belhaven had a practice of using the Lodge diary to record clinical and personal information about residents. As stated in a forthcoming opinion on another rest home, my expert, Lesley Spence, advised:

> "I consider that RNs should be writing daily progress notes with follow up in the following shifts by caregivers when the resident's condition changes or other events required documentation.
>
> …
>
> The use of an RN Communication Book is unusual and certainly not a safe practice — many facilities do use a handover book which highlights special events eg Dr coming to see Mrs A; special dressing ordered for Mrs B will be delivered by …; Mr J out until approx 10pm.
>
> It should not be used as a method of conveying nursing intervention which is recorded in the Nursing care plan and reinforced in the progress notes where necessary."[45]

In that opinion, I accepted the expert's advice that the use of the communication book by the registered nurse was an unusual and unsafe practice. However, I also accepted that the system was put in place by the rest home. In this case, I accept that Ms D's use of the Lodge diary was in line with the rest home's practice and, as the registered nurse, it would not have been easy for her to change this practice. Despite this, I remain of the view that her clinical documentation was substandard.

Summary
I accept that Ms D was for a time working only part time at Belhaven, and was not normally present when Mrs B visited her mother. I also accept that Ms C said that she would update the care plans and, as manager and nurse, she also had oversight of the care. However, as the registered nurse, Ms D clearly shared the responsibilities. While I acknowledge that the missing Lodge diary may have provided evidence that Ms D may have been conducting appropriate assessments and directing care staff, this unfortunately remains speculative on my part.

In my opinion, Ms D did not provide services to Mrs A with reasonable care and skill, and in a manner that complied with professional standards. Ms D should have ensured

[45] Opinion 09HDC01050.

that Mrs A's care plan was up to date and documented in Mrs A's file the changes to care, including those involving skin integrity, nutrition, continence, mobility, pain and behaviour. Ms D should have been regularly reviewing Mrs A's medications, evaluating the impact of changes to her medications, and appropriately documenting her observations. Ms D should have performed and recorded more frequent observations and assessments and updated Mrs A's care plan as appropriate. Ms D should have ensured that there was a wound care plan for Mrs A's groin rash.

To her credit, Ms D has recognised that aspects of her care could have been better, and she has taken steps to address this. I also acknowledge that she made a complaint to the DHB regarding Mrs A's care. Nonetheless, I also note that Ms Whitehead saw Ms D's failings in respect of documentation and medication management as particularly serious, and concluded that overall Ms D's care departed from expected standards to a moderate degree.

I consider that Ms D lacked insight into the level of care Mrs A required, and did not fulfil her responsibilities to manage and provide the care appropriately, and to adequately consult with Mrs A's family. Ms D's actions breached Rights 4(1) [46] and 4(2)[47] of Code of Health and Disability Services Consumers' Rights (the Code).

Breach — Ms C

Ms C was the nurse manager from 1 April 2008 to 4 February 2009. She had overall responsibility for supervising the care provided by Ms D and the caregivers, for ensuring that contractual requirements were met by the facility and its staff, and that a quality service was provided.

I do not accept Ms C's submission that she was not the clinical nurse manager. She said she managed the business. However, there is sufficient evidence that her role went beyond the purely administrative. Ms D, Ms J, Ms G and caregivers have all referred to Ms C as the Nurse Manager. This is recorded in various documents. She took direct responsibility for some of the registered nurse requirements in the DHB contract, including developing care plans, supervising and training staff, and developing policies and procedures.

Ms C also worked at Belhaven as a registered nurse, filling in for Ms D when she was not at the rest home. Ms C became the sole registered nurse after Ms D's resignation in September 2008. Ms C had a duty to treat Mrs A with reasonable care and skill, and in a manner that complied with legal, professional, ethical and other relevant

[46] Right 4(1): *Every consumer has the right to have services provided with reasonable care and skill.*
[47] Right 4(2): *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

standards. These standards are referred to in the expert advisor's report. In my view, Ms C did not provide Mrs A with appropriate care and skill in the following areas:

Assessment, care plans and evaluation
Mrs A's care plan was reviewed in November 2007.

In August 2008, Ms C asked Ms D to perform a number of assessments on Mrs A. It is not clear why these were undertaken or what was then done with the results. The findings usually stayed on a resident's file until the care plan was reviewed. Ms C was surprised and has been unable to explain why Mrs A's care plan was not reviewed following the assessments. Ms C believes that Ms D is solely responsible for the failure to review the care plan.

In response to my provisional decision, Ms C stated that she kept a diary of when the care plans were due for review, and informed Ms D. This diary had not previously been mentioned, and has not been provided or offered despite requests for all documentation and supporting evidence. Belhaven's policy and the DHB's contract required care plans to be reviewed every six months, and earlier if clinically indicated. Ms C should have ensured that Mrs A's care plan was reviewed in May 2008, six months after it was last reviewed, and again in August when her health and well-being began to deteriorate. Ms C should have been aware that the review of Mrs A's care plan was overdue. Ms C should also have noticed that the care plan was out of date when she covered for Ms D in July 2008 and from 26 August 2008.

The only change to Mrs A's care plan was on 30 September 2008 when Ms C added "apply cornflour under breast & groin". By that time, Ms C was the sole registered nurse as well as the manager.

Ms Whitehead commented:

> "The progress notes provide evidence that [Mrs A] was becoming more dependent and having ongoing issues with loose bowel motions, pain, mood swings, weight loss, and skin integrity problems and declining mobility that needed to be reflected in the care plans. There was a progressive and significant deterioration in the three weeks from the 25/09/08 to the 16/10/08. Following the diagnosis by the GP of the presence of an infection [Ms C] did not review [Mrs A's] care needs or provide instructions to care staff regarding her increasing care needs or whether she was well enough to go out in the van. The entries made in the progress notes by [Ms C] do not provide any reassurance that [Ms C] had identified the seriousness of [Mrs A's] condition or that she consulted the GP after October 9th 2008."

In response to my provisional decision, Ms C stated that she gave verbal instructions to care staff regarding Mrs A's "increasing care need" and "to turn her". All instructions should have been appropriately documented.

While I acknowledge that Ms D must share some of the responsibility for the unreviewed care plan, both registered nurses should have been ensuring that this document was kept up to date. Ms C, as manager, was also responsible for ensuring

that the rest home's policies, procedures, and contractual requirements were being met.

NASC referral
On 26 September 2008, nurse practitioner Ms G indicated that Mrs A might need to be referred for an assessment for an increase in care level to hospital level care. Dr H noted a similar opinion on 9 October. Ms G visited Belhaven on 10 October and made the referral to the Needs Assessment/Service Coordination (NASC) service.

Under Belhaven's contract with the DHB, Belhaven is responsible for contacting the family if a resident's condition changes significantly, and for referring the resident to the NASC service if there is a significant change in a resident's level of need and those needs can no longer be met by Belhaven. Ms Whitehead believes that Mrs A should have been referred to the NASC for reassessment of her care level earlier, and that the failure to make this referral contributed to Mrs A's clinical condition at the time of discharge to the private hospital. As the manager and RN, Ms C should have advocated for Mrs A and, in line with the contract, ensured she was referred to the NASC service sooner than she was.

Nutrition and weight loss
Mrs A was weighed on 25 September 2008. She had lost 4kg since being weighed the previous month. On 5 October, a caregiver had noted in the progress notes that Mrs A had lost 4kg. In October, caregivers often noted that Mrs A was eating very little. However, there is no documented evidence that Ms C assessed Mrs A, started a food and fluid chart to monitor her intake, reviewed her care plan or consulted the GP, the nurse practitioner or a dietician. If Ms C's system for monitoring BMIs only included data from when it was implemented, it may not have detected Mrs A's weight loss until 29 September 2008, if at all.

If Mrs A had a BMI of 26 in May 2008 when she weighed 60kg, then her BMI was likely to have been between 21 and 22 by October 2008 when she weighed 50kg. This is within the healthy weight range for an adult. Nonetheless, Ms Whitehead considered that the 13.8 percent weight loss (8kg) between August and October was significant and should have prompted further assessment and review of Mrs A's care plan. Ms Whitehead said that the magnitude of the weight loss was a clear indication of Mrs A's deteriorating health.

In response to my provisional decision, Ms C stated that "[a]ll issues were monitored appropriately and care was made to ensure [Mrs A] remained within the healthy range". No evidence of what this monitoring involved has been provided, but Ms C said that staff were "often" recording food intake in the Lodge diary, which has subsequently disappeared. Mrs A's care plan was not changed.

In my opinion, Ms C should have started a food/fluid chart to monitor Mrs A's intake, and at least considered having Mrs A assessed by a dietician in September 2008, if not before.

Medication management
Ms C should have identified and addressed the medication issues when she was covering for Ms D and particularly after Ms D resigned. As manager and RN she had a responsibility to ensure that medication was safely administered and in line with required standards. Of particular concern is the possible delay in administering the Augmentin prescribed on 9 October 2008. As Ms Whitehead has noted, the records suggest that the first dose was not given until the day after this antibiotic was prescribed for Mrs A's infection. Ms C stated that the antibiotic arrived at the home after she had left for the day, and therefore she was unable to administer it. Ms C should have left written instructions for staff, and could have telephoned the rest home in the evening to ensure that the antibiotic had arrived and been administered. I note that Ms D said she telephoned staff when she had concerns about medication.

Ms C also had overall responsibility for ensuring that staff were aware of potential side effects. Ms C provided only one staff training session on medication on 2 April 2008, despite Ms D reporting that staff were making medication errors, including the two reported incidents involving Mrs A's furosemide in May and July 2008.

Ms Whitehead advised that Ms C failed to ensure that medications were managed in accordance with the required standards. She also advised that the laxatives and/or faecal impact might have been causing Mrs A's loose bowel motions. In Mrs A's last week at Belhaven, the Augmentin prescribed for her infection could also have contributed to the problem. The loose bowel motions in turn may have contributed to the excoriation of Mrs A's groin and buttocks. Ms Whitehead said that Ms C should have reviewed the use of laxatives for Mrs A.

In response to my provisional decision, Ms C stated that "[b]owel records showed regular bowel movements or laxatives given". No bowel records have been provided, the progress notes show frequent episodes of loose bowel movements, and the medication charts show frequent administration of laxatives.

Ms C appears to accept no personal responsibility for medication issues when she was the only registered nurse at the rest home.

Pain management
Ms Whitehead was also very critical of Ms C's response to Mrs A's pain in her final week. Staff noted that when they moved any part of her body Mrs A was sore. In response to my provisional decision, Ms C advised that Mrs A was receiving her regular Panadol in her last week at Belhaven. However, the pain section of Mrs A's care plan was not updated after 14 November 2007, despite changes to her medication and increasing reports of pain.

Skin integrity
In relation to Mrs A's skin rashes, Ms Whitehead commented that "because of the substandard documentation I was not able to establish the full picture of the treatment and progress". Ms C was informed of Mrs A's groin rash on 7 July 2008. Ms C was the only registered nurse at Belhaven between 4 July and 21 July, when caregivers were frequently reporting on the groin rash. She did not complete a wound care plan

or enter the treatment in Mrs A's care plan as per Belhaven's policy. She did not document in the progress notes all of her assessments of the rash. Furthermore, Ms Whitehead has not been able to locate any evidence-based practice to support the use of cornflour powder in the treatment of skin rashes.

Ms C stated that at no time did she consider that Mrs A required a separate wound care plan for the rash. This was despite the ongoing problems and several attempts to treat the rash with various medications and treatments. In response to my provisional decision, Ms C stated that Ms D was responsible for ensuring that the care plan was appropriate for the rash. However, Ms C was the only registered nurse on duty when Ms D was on holiday, working part time, and after she resigned. Ms C, as manager, should have been ensuring that all staff, herself included, followed Belhaven's policies and procedures.

Ms Whitehead is of the view that the pressure ulcers found on Mrs A's arrival at the private hospital probably developed once she stopped moving, in her last three to four days at Belhaven. However, there is no documented evidence of the pressure ulcers in the progress notes.

Ms Whitehead advised:

> "There is evidence that [Mrs A] had become completely dependent and was not moving herself in the last two days she resided at Belhaven Rest Home. There is no evidence that [Ms C] assessed the level of risk for developing pressure ulcers or reviewed the plan of care and instructed care staff in pressure ulcer prevention. Had [Ms C] done so, it is unlikely that the pressure ulcers would have developed."

Belhaven's Skin Assessment Policy states: "Re-assess all residents skin integrity and pressure area risk monthly or more often if their medical or psychological condition changes."

On 13 October 2008, Ms G requested that Mrs A be turned every two hours. In response to my provisional decision, Ms C advised that she had given verbal instructions to staff to turn Mrs A. However, it was not until 15 October that a caregiver recorded this instruction in the progress notes. Ms C did not document an assessment of Mrs A's pressure area risk or update Mrs A's care plan.

In response to my provisional opinion, Ms C requested my expert to comment as to "whether she can rule out the possibility that the bruises would have occurred in a short time at no fault of the carers". Ms Whitehead conceded that the pressure ulcers could have occurred in as little as 4–6 hours, but were preventable (see Appendix B). Ms Whitehead advised that

> "it was the role of the registered nurse/nurse manager to:
>
> 1. identify the increasing deterioration in Mrs A's health early in the decline,
> 2. adequately instruct the care givers,
> 3. ensure that the care givers were competent to provide the required care,

4. ensure that the care givers provided the care required and
5. review and evaluate the progress of the resident".

In my opinion, Ms C did not adequately assess, treat and monitor Mrs A's groin rash. Ms C did not identify early enough that Mrs A was at risk of developing pressure sores, and did not ensure that staff were turning Mrs A when she became relatively immobile, and after it was requested by the nurse practitioner.

Communication with family
As previously discussed, there appeared to be confusion over who was responsible for communicating with Mrs A's family. Ms C stated that Ms J took responsibility for public relations with residents and relatives, whereas Ms J stated that she "used to have more contact with Mrs B … But Ms C took more responsibility for contacting families, particularly around clinical issues." Regardless of the confusion, as manager and RN, Ms C should have been communicating with the family whenever she had interactions with Mrs A that warranted an intervention or a change in her routine. This would have helped build confidence in the service, and also would have ensured that Mrs B could understand the issues Ms C and the staff were facing in providing care to Mrs A.

I acknowledge that while she was nursing at Belhaven, Ms D also had some responsibility for communicating with Mrs A's family. However, in my opinion Ms C's communication with Mrs B was inadequate. There is documented evidence that she communicated twice with the family, but there should have been a great deal more communication, particularly over the last three weeks when Mrs A's condition was deteriorating significantly. Furthermore, it was not appropriate to add a note of condolence to the final invoice. This was very insensitive.

Mood swings/behaviour management
Ms Whitehead advised that Ms C failed to meet her responsibilities to ensure that there was ongoing assessment, care planning and evaluation of Mrs A's behaviour. Over the last three weeks that Mrs A was at Belhaven, "she obviously had significant aggressive episodes and significant periods of sleepiness". Ms Whitehead acknowledged that the nurse practitioner was being consulted, but said that Ms C was responsible for ensuring the safety of Mrs A, other residents and staff. Ms C should have ensured that the care plan addressed this. Like Ms D, Ms C was also responsible for reviewing medications and their effects, and liaising with the general practitioner and nurse practitioner.

Incident reporting
Ms C was responsible for incident reporting and follow-up action. Very few incidents were properly reported, and Ms Whitehead has advised that the quality and follow-up of the reports that were done was poor. Ms C failed to ensure that all incidents were documented and adequately investigated, and corrective action taken.

Documentation
Registered nurses are required to document accurately and fully a resident's observations, progress, and findings from any clinical examinations conducted. In a

rest home setting, the manager is responsible for supervising and ensuring that nursing and caregiving staff keep good notes, since documentation is an essential part of good quality care.

The author of any documentation in the clinical record must be identifiable. Belhaven's guidelines for documentation stated that entries in the progress notes were to be signed, name printed, and designation documented. Most entries in Mrs A's progress notes were not identifiable. To her credit, Ms C's entries complied with the policy. However, Ms C, as manager, had a responsibility to ensure that the organisation's policies and procedures were also correctly implemented by other staff. The evidence shows that frequently this did not occur.

Ms Whitehead advised that Ms C did not meet the standards required for documentation, including incident reporting. Ms C's peers would expect "the communication in the clinical record to tell the whole story about Mrs A's care, show her observations and how she acted on them, show continuity of care, show care delivered following her observations and show how Mrs A responded to care and medications and other treatments".

Ms Whitehead commented that there was little documented evidence of Ms D's and Ms C's responses to Mrs A's deteriorating health. Some of this may well have been documented in the missing Lodge diary. In Ms Whitehead's opinion:

> "[Ms C], [Ms D] and Belhaven Rest Home & Dementia Care did not ensure that the standard of care that [Mrs A] could expect occurred. This is more serious in the case of [Ms C]. In the last three weeks of [Mrs A's] stay at Belhaven … [Ms C] provided no documented evidence that she had assessed and identified the seriousness of [Mrs A's] deterioration, had adjusted the care accordingly or consulted with the GP."

Ms C was also responsible for staffing at the rest home. This included ensuring that all employment-related documentation was in order, and performance reviews were conducted according to Belhaven's policies and procedures. This did not happen for Ms D.

Summary
Ms C had oversight of Mrs A's care both as the manager and when she became the sole registered nurse. Ms C took personal responsibility for reviewing care plans and for wound management. However, she did not review Mrs A's care plan, or ensure it was done by someone else. This was despite Belhaven's policy and the DHB contract requiring six-monthly reviews or more frequently if clinically indicated. Ms C did not develop a wound care plan, despite Mrs A's recurring groin rashes. She did not recognise that Mrs A was losing a significant amount of weight and monitor this, or consult with or refer her to a dietician. Ms C did not act on the indications from Ms G and Dr H and ensure that Mrs A was promptly referred for a needs assessment. Ms C did not recognise that Mrs A was at risk of developing pressure sores and provide written instructions for the caregivers and ensure that these were followed, or ensure that incidents were properly reported and followed up.

Ms Whitehead has advised that Ms C's failure to ensure that Mrs A received adequate nursing care, her failings in respect of care planning and assessment, documentation, medication management, her poor response to Mrs A's weight loss, skin rashes and ulcers, and the lack of communication with the family, represent a severe departure from the expected standards.

In my opinion, Ms C's response to my provisional decision demonstrates a lack of insight into the standard of care provided to Mrs A, and her responsibility for it. Ms C was Ms D's manager and also filled in for her when she was on holiday and after she resigned. Therefore, Ms C was in a unique position to identify departures from Belhaven's policies and procedures. During the investigation, Ms C told HDC that she "did not identify any issues with the care [Ms D] was providing". Now she is of the view that the failings in the care were Ms D's.

Ms C also believes that, after Ms D resigned, Belhaven was responsible for hiring another registered nurse, and "any observed lack of care" is the responsibility of Belhaven. However, one of Ms C's responsibilities as manager was the employment of staff. Belhaven claim that Ms C "had full rights to hire what ever staff was required". I acknowledge that Ms C was effectively working two jobs. However, the directors were assisting her with the management of the rest home, and she could call on Ms G and Dr H as required for clinical matters. I note that Ms C did not make the same excuse for the periods when Ms D was on holiday and when Ms D was working part time.

Ms C feels she has committed no wrong, and the blame lies with Ms D and Belhaven. I do not accept this.

Mrs A was not provided with quality care, and Ms C must bear significant responsibility for this. Ms C did not provide sufficient oversight and guidance to her staff on the care Mrs A needed, consult adequately with Mrs A's family, or respond appropriately to Mrs A's deterioration. Therefore, Ms C did not provide services to Mrs A with reasonable care and skill that complied with professional standards. For all of the reasons outlined above, in my opinion, Ms C breached Rights 4(1) and 4(2) of the Code.

Breach — Belhaven Rest Home Limited

Belhaven was required to provide good care to Mrs A in line with legislative and contractual obligations, such as the Health and Disability Services Standards referred to by the expert advisor. It needed to have systems, policies and procedures in place to ensure that its staff provided an appropriate level of care to Mrs A, responded promptly and appropriately to her changing condition and, when it was clear she needed a higher level of care, ensured she was reassessed in a timely fashion and managed in the meantime. It also needed to ensure there was compliance with its policies and procedures, particularly those directly relating to the care of residents.

However, there is significant information, backed up by the DHB's audit, that Ms D and Ms C were not alone in their failure to deliver services of an appropriate standard to Mrs A. There were also a number of instances where, as Ms Whitehead has noted, various staff did not follow Belhaven's own policies and procedures in caring for Mrs A. Clearly there were wider systemic issues at Belhaven at the time of these events, and Belhaven and its directors must take overall responsibility for the failings in Mrs A's care.

Oversight and support for staff
The directors were present and contributed to the daily running of Belhaven but relied on Ms C to run it. In my view, the informality of these arrangements and the lack of clear oversight and management directly impacted on the care provided to Mrs A by Ms C and other staff.

Ms Whitehead advised that "Belhaven failed to provide adequate clinical governance and quality assurance structures". It is particularly telling that the DHB audit carried out soon after this complaint found a number of service areas requiring corrective actions. As Ms Whitehead advised, if adequate clinical auditing and risk management had been in place at Belhaven, then the issues with clinical effectiveness, documentation, assessment and care planning and medication management may have been identified and addressed much earlier. Mrs A's care would have been improved.

In my opinion, Belhaven failed to adequately support Ms C in her role as manager. Ms C was supposed to provide monthly reports to the directors, and current information relating to service delivery. No evidence has been provided that she delivered these reports. The directors were available to her, but there were no regular formal meetings or review of incidents. This contributed to issues not being identified quickly and then dealt with as appropriate. Ms Whitehead was particularly concerned about the lack of incident reporting, review and follow-up in relation to Mrs A's behaviour. There is no evidence that Belhaven's directors took steps to ensure that the facility's policies and procedures were being followed. They did not formally sign off changes to those policies and procedures. Furthermore, no performance appraisal was conducted for Ms C. Under her contract, she should have had her first performance appraisal in July 2008. The systems were not robust.

Ms D also felt that she was not adequately supported and supervised in her role as registered nurse. This subsequently led to her resignation. Ms D expressed her wider concerns about the delivery of care at Belhaven, particularly staff training and competency, and felt that she was not adequately supported by Ms C and Belhaven in her efforts to effect change.

Both Ms D and Ms C reported having little or no orientation when they started at Belhaven, beyond a tour of the facility and being given health and safety information. Belhaven had a staff induction/orientation policy for caregivers, but apparently not for the manager or registered nurse. Belhaven did not ensure that Ms C and Ms D received an orientation programme for working in the dementia unit as required under the DHB's contract. Ms D also had no formal performance appraisal. Under Belhaven's policy she should have had an initial appraisal by June 2008.

Clarity of roles and responsibilities
Communications were rarely appropriately documented, and there was confusion over who was responsible for communicating with Mrs A's family. It was Belhaven's responsibility to clarify who would communicate with family members and under what circumstances.

There was similar confusion about who should review and update care plans. Ms Whitehead commented on the urgent need for roles to be clarified in the job descriptions, particularly the nursing role. She also noted the inappropriateness of non-clinical directors taking any responsibility for tasks related to clinical care. Belhaven, as a result of the DHB audit, has updated the manager's and registered nurse's job descriptions.

Belhaven needed to ensure that the roles of the manager, registered nurses and the directors were clearly defined, and that all parties understood their roles and responsibilities and how they worked together.

Documentation
Belhaven was not able to provide many of the documents requested by HDC, either because they had been lost or never existed. Both Ms D and Ms C stated that the documentation at Belhaven when they started was disorganised and incomplete. Ms Whitehead has described the documentation as "substandard". As the former Commissioner has stated previously, "… records are an essential tool for patient management, for communicating with doctors and health professionals, and for ensuring continuity of care".[48] Belhaven should have ensured that documentation met sector standards and the requirements of the DHB contract, and was easy to locate.

Reassessment of Mrs A
Ms Whitehead has advised that in failing to ensure that Mrs A was promptly reassessed when the nurse practitioner first raised it on 26 September 2008, Belhaven staff did not meet the facility's contractual requirements with the DHB. While Ms Whitehead was critical of Ms C, she was also very critical of Belhaven for failing to ensure that these standards were met.

Ms Whitehead advised that the delay in having Mrs A reassessed represented a severe failure by the facility.

Summary
I note that following the DHB audit, Belhaven took prompt action, implementing a range of measures to improve the quality of care provided at the home and to minimise the likelihood of a similar event occurring again. I also note that the directors of Belhaven are now kept more informed about the health of its residents. However, it is inappropriate and unnecessary for them to sight all wounds and become involved in clinical care. It is more appropriate that non-clinically trained directors of

[48] Opinion 06HDC12164.

a company ensure that documentation and policies are in place, and that regular communication takes place with the clinical staff, such as with the nurse and nurse manager.

As I stated in a recent opinion involving another rest home,[49] "It is a fundamental requirement that a dementia unit will be able to provide appropriate care to dementia patients and promptly recognise when they are no longer able to do so. [The rest home] did not have adequate systems available … to ensure that this requirement was met. Neither did it sufficiently support [the registered nurses] to enable them to do this."

In another opinion about a different rest home,[50] I was of the view that "[t]he inaction and failure to follow policies … demonstrates a culture of non-compliance, systemic failings, and an environment that did not sufficiently support and assist staff to do what was required of them. The Home must take responsibility for this."

I hold a similar view in relation to the failings in the care provided to Mrs A at Belhaven Rest Home. Belhaven was required to provide care to Mrs A with reasonable care and skill, and that complied with all the relevant standards and met its contractual responsibilities. Belhaven failed to ensure these obligations were delivered, particularly in relation to the review of Mrs A's care plan, communication with her family, and the need for timely reassessment by Needs Assessment and Service Co-ordination Services. In my opinion, Belhaven Rest Home breached Rights 4(1) and 4(2) of the Code.

Recommendations

I recommend that Ms D:

- Provide a written apology to Mrs A's family for her breaches of the Code. The apology is to be forwarded to HDC by **30 July 2010** for sending to the family.

I recommend that Ms C:

- Provide a written apology to Mrs A's family for her breaches of the Code. The apology is to be forwarded to HDC by **30 July 2010** for sending to the family.

- Review her practice in light of this report, particularly her assessment and care planning, wound management, medication management and documentation, and advise me by **30 August 2010** of any changes she has since implemented.

[49] Opinion 08HDC17105.
[50] Opinion 07HDC16959.

I recommend that Belhaven:

- Review the progress made in updating its policies and procedures and restructuring the management and quality structures at Belhaven, and report back by **30 August 2010** on steps taken to address the issues highlighted by this report, my expert advisor, and the DHB's audit.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand with a recommendation that it consider whether reviews of Ms D's and Ms C's competence are warranted.

- A copy of this report will be sent to the Ministry of Health (HealthCert) and the District Health Board.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Belhaven Rest Home Limited, will be sent to the College of Nurses Aotearoa, the New Zealand Nurses Organisation, and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Expert advice from registered nurse Noeline Whitehead

Medical/Professional Expert Advice 09/01035
Independent Advisor's Report

1.0 Section one

1.1 Request for an opinion

I, Noeline Whitehead, have been asked to provide an opinion to the Commissioner on case number 09/01035 and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

1.2 Qualifications and experience

My qualifications are:
New Zealand Registered Nurse holding a current practising certificate, Post Graduate Diploma in Health Science, Master of Nursing (1st Class Honours) and currently a full time Doctoral Student with a University of Auckland scholarship.

I have thirty-two years in senior nursing positions:

- Nurse manager and general manager for a group of long term care hospitals and a rest home in Auckland
- Clinical Nurse Director for Health of Older People at Counties Manukau District Health Board (full time) 2005 to 2007 and currently for Age Related Residential Care (part time)
- I have a consulting business that provides consultancy services and education to the Age Related Residential Care Sector
- I was appointed Temporary Manager on two occasions by District Health Boards under the Age Related Residential Care service provider agreement
- I was a team leader surveyor and lead auditor for ten years for Quality Health New Zealand

My areas of expertise are standards of practice, quality of care, advanced clinical nursing practice, research and evidence based practice related to Age Related Residential Care and Health of Older People.

1.3 Instructions from the Commissioner

To advise the Deputy Commissioner whether, in my opinion, Belhaven Rest Home, manager registered nurse [Ms C], and registered nurse [Ms D] provided services to [Mrs A] of an appropriate standard.

I. Were the services provided to [Mrs A] appropriate?
II. What standards apply in this case?
III. Were those standards complied with?

1.3.1 [Ms D]

Did [Ms D] provide an appropriate standard of nursing assessment and care to [Mrs A]? Please comment with specific reference to:

- care planning
- medication
- personal care needs
- nutrition

Did [Ms D] communicate appropriately with [Mrs A's] family?

1.3.2 [Ms C]

Did [Ms C], as (Nurse) Manager, take appropriate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mrs A]?

Did [Ms C], as a registered nurse, during the absences of [Ms D], provide an appropriate standard of nursing assessment and care to [Mrs A]? Please comment with specific reference to:

- care planning
- medication
- personal care needs
- nutrition

Did [Ms C] communicate appropriately with [Mrs A's] family?

1.3.3 Belhaven Rest Home

Were there adequate clinical governance and quality structures in place at Belhaven Rest Home?

Was [Ms C] adequately supported?

Was [Ms D] adequately supervised and supported?

What else, if anything, should Belhaven Rest Home have done in the circumstances?

Please comment on the initiatives designed to improve services at Belhaven Rest Home since these events.

Please provide any further recommendations for improvement.

Are there any aspects of the care provided by Belhaven Rest Home, [Ms C], and [Ms D] that you consider warrant additional comment?

1.4 Sources of Information

- Letter of complaint to the Commissioner from Mrs B, dated 12 March 2009, marked with an "A". (Pages 1 to 3)

- Letter from Mrs B, received 30 April 2009, marked with a "B". (Pages 4 to 6) [Including photographs]
- Letter from Mrs B, dated 8 June 2009, marked with a "C". (Pages 7 to 8)
- Letter from [the] Private Hospital, dated 24 April 2009, marked with a "D". (Pages 9 to 19)
- Letter from [the] DHB, dated 29 April 2009, marked with an "E". (Pages 20 to 39) [Excluding draft audit report]
- Letter from [the] DHB, dated 18 June 2009, marked with an "F". (Pages 40 to 42) [Excluding draft audit report]
- Letter from [the] DHB with final audit report, dated 3 July 2009, marked with a "G". (Pages 43 to 82)
- Response from Belhaven Rest Home (by [Ms C]), dated 20 April 2009, marked with an "H". (Pages 83 to 84) [Excluding attachments]
- Response from Belhaven Rest Home, dated 10 June 2009, marked with an "I". (Pages 85 to 179) [Excluding draft audit report; and progress notes, incident forms and medication charts prior to April 2008]
- Response from Belhaven Rest Home, dated 26 June 2009, marked with a "J". (Pages 180 to 353)
- Fax from Belhaven Rest Home dated 6 July 2009, marked with a "K". (Pages 354 to 365)
- Response from Belhaven Rest Home, dated 28 July 2009, marked with an "L". (Pages 366 to 367)
- Fax from Belhaven Rest Home, dated 7 August 2009, marked with an "M". (Page 368)
- Response from RN [Ms C], dated 11 June 2009, marked with an "N". (Pages 369 to 384)
- Response from RN [Ms C], dated 29 July 2009, marked with an "O". (Pages 385 to 393) [Excluding character references]
- Response from RN [Ms D], dated 30 July 2009, marked with a "P". (Pages 394 to 399)
- Response from Dr H, dated 3 August 2009, marked with a "Q". (Pages 400 to 425)
- Notes taken during an interview with RN [Ms D] on 10 September 2009, marked with an "R". (Pages 426 to 430)
- Notes taken during an interview with RN [Ms C] on 10 September 2009, marked with an "S". (Pages 431 to 445) [Including Care Plan template]
- Notes taken during an interview with [Ms J] at Belhaven Rest Home on 10 September 2009, marked with a "T". (Pages 446 to 448)
- Notes taken during an interview with [Mrs B] on 10 September 2009, marked with a "U". (Pages 449 to 451)

1.5 The standards that apply to this complaint

This complaint extended over the period of the introduction of the revised Health and Disability Sector Standards in 2008; therefore both the 2001 and 2008 standards are included:

- NZS 8134:2001. Health and disability sector standards (Standards New Zealand, 2001a)
- NZS 8141:2001. Restraint minimisation and safe practice (Standards New Zealand, 2001b)
- NZS 8141:2000. Infection control (Standards New Zealand, 2000)
- NZS 8134:2008. Health and disability sector standards. Superseding NZS8134:2001. NZS 8141:2000, AND NZS 8143:2001 (Standards New Zealand, 2008)
- Age related residential care service agreement 2007 and 2008 (New Zealand District Health Boards, 2007 and 2008)
- Competencies for the registered nurses (Nursing Council of New Zealand, 2007)

1.6 New Zealand guidelines relevant to this complaint

The following guidelines are relevant to this complaint:

- Safe Management of Medicines. A Guide for Managers of Old People's Homes and Residential Care Facilities (Ministry of Health, 1997b)
- Guidelines for the Support and Management of People with Dementia (Ministry of Health, 1997a)
- NZS 8153:2002. New Zealand Standard Health Records (non mandatory) (Standards New Zealand, 2002)
- Reportable Events Guidelines (Ministry of Health, 2001)

1.7 New Zealand evidence based practice recommendations relevant to this case

The following evidence based practices are relevant to this complaint:

- SNZ8163:2005 Handbook indicators for safe aged-care and dementia-care for consumers (Standards New Zealand, 2005)
- Audit tool for measuring compliance with the Agreement for Age Related Residential Care Services (Ministry of Health, 2002)
- Guidelines for nurses on the administration of medicines (New Zealand Nurses Organisation, 2007)
- Documentation (New Zealand Nurses Organisation, 1998a)
- Incident reporting (New Zealand Nurses Organisation, 1998b)

1.8 Reference list

A reference list for accessing these documents is located at the end of the report.

1.9 List of abbreviations used

Age related residential care	ARRC
General practitioner	GP
Nurse Practitioner	NP
Registered nurse	RN
Kilograms	kg

Section 2

2.0 The standards of care applied

The standard of care provided to [Mrs A] is reviewed and considered using the following standards:

2.1 Assessment

The competencies for the registered nurses, competency 2.2 (Nursing Council of New Zealand, 2007) requires that the registered nurse undertakes a comprehensive and accurate nursing assessment of the resident. The responsibility for nursing assessment is within the scope of practice of the registered nurse(s).

NZS 8134:2001 — 4.1 and 4.2 (Standards New Zealand, 2001a) and NZS 8134:2008 — 3.4.2 (Standards New Zealand, 2008) require that residents receive services that meet their individual assessed needs, that assessment is undertaken by a suitably qualified services provider, assessment is developed in partnership with the resident and/or family and is documented to a level of detail required to demonstrate the needs of the resident.

2.2 Care planning and management of care

The competencies for the registered nurses, competency 2 (Nursing Council of New Zealand, 2007) requires that the registered nurse contributes to care planning. Nursing Council competency 1.3 for registered nurses states a registered nurse is required to demonstrate accountability for directing, monitoring and evaluating the nursing care provided by others (Nursing Council of New Zealand, 2007).

NZS 8134:2001 — 4.1 and 4.2 (Standards New Zealand, 2001a) and NZS 8134:2008 — 3.5.2 (Standards New Zealand, 2008) require that needs identified via the assessment processes form the basis of a service delivery plan completed by a suitably qualified services provider, is developed in partnership with the resident and/or family and is documented to a level of detail required to demonstrate the needs of the resident. Service delivery plans are individualised, updated, describe the required support/interventions required to achieve the desired outcomes or goals and demonstrate service integration.

ARRC Service provider agreements (New Zealand District Health Boards, 2007 and 2008) require that on admission an assessment is completed that covers the physical, psycho-social and cultural aspects and that this information is used to develop an initial care plan. In addition, they require the resident and their nominated representative have input into the care plan. It clearly places the responsibility for care planning with the registered nurse. For dementia units assessments should include a description that addresses that Subsidised Resident's current abilities, level of independence, identified needs/deficits, and takes into account the Subsidised Resident's habits, routines, idiosyncrasies, and specific behavioural management strategies; strategies for minimising episodes of challenging behaviours based on assessment and prevention; and a description of how the behaviour of the Subsidised Resident is best managed over a 24-hour period.

NZS 8134:2001 — 4.5 (Standards New Zealand, 2001a) and NZS 8134:2008 — 3.4, 3.5, and 3.8 (Standards New Zealand, 2008) require that individual service plans are evaluated in a comprehensive and timely manner detailing the degree of achievement/response to interventions/care and changes are made when the response is less than expected.

ARRC service provider agreement D16.3 and D16.4 (District Health Boards New Zealand, 2008) requires ongoing review and evaluation when there is a significant change in the resident's clinical condition and at least six monthly.

2.3 Communication

NZS 8134:2001 Part 1 (Standards New Zealand, 2001a) and NZS 8134:2008 — 1.8 (Standards New Zealand, 2008) require that there is effective communication with the resident/family.

New Zealand RN competency 3.3 requires effective communication with clients/families.

The ARRC service provider agreement requires that the involvement of family/whanau and support is promoted at all times (District Health Boards New Zealand, 2008).

2.4 Documentation

NZS 8134:2001 — 5.2 and NZS 8134:2008 — 2.9.10 require that all records pertaining to the resident are integrated. NZS 8134:2001 — 5.2 and NZS 8134:2008 — 2.9.9 require that all records are legible and the name of the service provider is identifiable.

2.5 Requirements of a manager of a rest home

ARRC service provider agreement D17.3 states that the role of the manager includes, but is not limited to ensuring subsidised residents of the home are adequately cared for in respect of their everyday needs (District Health Boards New Zealand, 2008).

2.6 Medicine Management

NZS 8134:2001 — 5.3.1 and NZS 8134:2008 — 3.12.1 require that there is safe and appropriate prescribing, dispensing, administration and review that complies with legislation and guidelines.

2.7 Standards of care

NZS 8134:2001 Part 4 and NZS 8134.2:2008 — 1.8.1 and 3.6 New Zealand require that provision of services are consistent with and contribute to meeting the resident's assessed needs and desired outcomes. Residents are entitled to receive services of an appropriate standard.

The ARRC service provider agreement requires that the facility ensures the needs of each Subsidised Resident are met in a caring, comfortable, safe environment that maximises individuality, privacy and health potential.

Section 3

3.0 Summary of [Mrs A's] care 1/4/2008 to 16/10/08

3.1 Background

[Mrs A] began receiving short periods of respite care at Belhaven Rest Home from 11 September 2004, and became a permanent resident from 20 October 2005. On 2 November 2006, [Mrs A] was assessed as eligible for dementia care at Belhaven Rest Home.

From the beginning of October 2008, [Mrs A's] daughter had noticed deterioration in [Mrs A's] condition.

On 16 October 2008, [Mrs A] was transferred to [a private hospital]. On arrival she was assessed and photographs were taken of large black blisters to each heel, and excoriation around vulval and perineal areas and left hip. [A few days later], [Mrs A] died.

3.2 Diagnosis and medications

[Mrs A's] health problems included:

- Severe dementia
- Severe heart failure
- Renal failure
- Cancer of the breast
- Hypertension
- Postural hypotension
- Anaemia

Her prescribed medications during the period 1st April to 16th October 2008 were:

• Diurin 40 mg	2 tabs am and 1 tab 2pm
• Anten 10mg	1 cap daily
• Inhibace 0.5 mg	2 tabs am
• Genox 20 mg	1 tab am
• Ridal 0.5mg	½ tab am and nocte
• Heartcare Aspirin 150mg	1 tab am
• Span-K 600mg	1 tab am
• Dilatrend 6.25 mg	one tab am and nocte
• Paracetamol Tabs 500mg	2 tabs 4 times a day appears to have been given PRN
• Nozinan 25mg	¼ tab at lunchtime commenced 23/05/2008 ceased 15/08/08
• Celapram 20 mg	½ tab am commenced 26/09/08

She had a short course of the following medications:

• Pimafucort ointment	commenced 24/07/08
• Lamisil tablets	commenced 14/08/08 and completed 12/09/08

- Augmentin capsules commenced 09/01/08

Also being given and signed for but not on the prescribing medication chart was:

- Laxsol Tabs 2 tabs twice a day
- Lactulose 15 ml twice a day

3.3 General Practitioner consultations

The General Practitioner (GP) caring for [Mrs A] saw her on the following dates: 10/04/08, 25/5/08, 24/7/08, 14/8/08, 21/8/08, 28/8/08, 5/9/08, and 9/10/08. Notes provided substantiate this.

3.4 Nurse Practitioner consultations

The Nurse Practitioner (NP) from [the] District Health Board provided 10 consultations regarding [Mrs A's] care, specifically the aggressive behaviour and sleepiness and attended a meeting with the daughter regarding levels of care on October 13th. Notes provided substantiate this.

3.5 Primary source of information

The progress notes have been the primary source of information in establishing [Mrs A's] health status and the care provided from 01/04/2008 to 16/10/2008. It appears that most of the entries have been made by the care givers. It has not been possible to identify the persons making the entries with the exception of six entries made by [Ms C] the Nurse Manager. Entries have been initialled or, if signed, the signature is illegible in most cases. Belhaven have not been able to provide a master list of signatures. Therefore some entries may have been made by [Ms D], the registered nurse, but I have been unable to substantiate this.

3.6 Summary by month

The evidence provided did not include comprehensive documentation of all care and interventions provided to [Mrs A]. There are frequent reports of personal hygiene procedures, and food and fluids being provided.

3.6.1 April 2008

In April 2008 [Mrs A] was slowly mobile on a walking frame, fed herself, and needed assistance with showering and dressing, and able to take part in trips out in the van. She was reported to be alert but inclined to wander and to be restless. The first entry in the progress notes for the period on 7th April 2008 indicated that [Mrs A] had been out with her family and was eating and drinking well. On April 25th the care staff reported that she was lethargic and flushed. Her temperature was recorded as normal.

Skin

[Mrs A] complained of an itchy vaginal area on 28/04/08. This itching appeared to have been causing [Mrs A] a reasonable level of distress evidenced by her actions as reported by the care staff. An unidentified cream was applied. The care plan (page 00275) stated that a moisturizer (Lemnis) was to be used p.r.n. The care staff reported a rash on her buttocks 30/04/08 was healed and Lemnis Cream was still applied.

Bowels
[Mrs A] was given laxatives on most days. Care staff reported episodes of loose bowel motions.

Pain
Care staff reported that [Mrs A] suffered with pain in her legs and that she was given paracetamol from time to time.

Mood
During April [Mrs A] was reported to have periods of wandering, agitation, and being sleepy.

Weight
[Mrs A] was reported to be eating well. No documented evidence of weights has been provided from January to and including April 2008. On discharge from [the] Hospital in January 2008 [Mrs A's] weight was 60 kg.

3.6.2 May 2008
[Mrs A] was commenced on Nozinan on the 23/05/08. There was no documented evidence as to the reason for commencing this drug or follow-up of its effectiveness. The first reported episode of aggressive behaviour was reported on the 26/05/08 three days after the commencement of Nozinan. Her urine was checked for the presence of infection by the care staff.

Skin
On 5th May a small excoriated area at the top of the buttocks was reported. A plan of care was documented in the progress notes for this. Care staff reported on the state of this excoriated area daily and reported it was healed on 7th May 2008.

Bowels
[Mrs A] was given laxatives on most days. Episodes of loose bowel motions were reported.

Pain
Frequent episodes of pain were reported. On May 22nd paracetamol was prescribed regularly for pain. There was no documented evaluation of the effectiveness of this change. Leg pain was still being reported after this date.

Mood
During this month periods of agitation, being tired and sleepy.

Weight
[Mrs A's] weight was recorded as 60 kg on May 27th 2008. Staff continued to report that she was eating and drinking well.

3.6.3 June 2008
[Mrs A] suffered a fall on the 24/06/08 that left her with a bruised and swollen right side of her face. While there is an entry in the progress notes by [Ms C] regarding the

bruising on [Mrs A's] face there is no documented evidence that the family or the GP were contacted regarding the fall. On the 27/06/08 there was a report of a bruise on [Mrs A's] right hip.

Skin
On the 28/06/08 a rash around the "vagina" was reported red and itchy. An unidentified cream was applied. The RN was informed of the rash on 30th June, 2008.

Bowels
[Mrs A] was given laxatives on most days. There were no reports of incidents related to bowels.

Pain
[Mrs A] was reported to be refusing to take the paracetamol some mornings. The RN was informed of this on 30/06/08.

Mood
Aggressive episodes and the degree of aggression increased in June 2008. Aggressive episodes being reported appeared to be linked to showers and other residents. Care staff reporting periods of [Mrs A] being sleepy.

Weight
The first reported episode of refusing to eat was reported on the 02/06/08 at which time [Mrs A] stated "feeling unwell". On the 29/06/08 [Mrs A] was reported as refusing to eat. No weights were recorded.

3.6.4 July 2008
On 03/07/08 care staff reported that at times [Mrs A] needed full assistance with care. On 16th July [Mrs A] refused to eat and was reported as very confused and unsettled. The following day care staff reported that she was not well and recorded her temperature as 37.1°C.

Skin
On the 02/07/08 the "rash" was reported to be bleeding. On 6th July the "rash" was reported to be worse and to be very itchy and red. An entry in the progress notes on 7th July queried the cause of the rash, indicated that the skin was broken and that the nurse manager was advised. A plan of care was documented in the progress notes requesting twice daily showers if possible. There was a report on 8th, 9th and 10th July that the rash was improving, but worse and very itchy again by the 12th July. There was blood being reported on pads and underwear. By the 16/07/08 the rash was reported to have improved somewhat. On the 21/07/08 it is documented that the RN was aware that the rash was not as red but still itchy.

On the 23/7/08 the GP prescribed Pimafucort ointment in the medical progress notes. Some of the care staff documented in the progress notes when this has been applied but it was not documented or signed for on the medication chart. On July 26th staff reported the rash was still looking red and the next day reported it was "redder".

Bowels
Loose/soft bowel motions were reported from time to time. On 23rd July there was a request in the progress notes to withhold laxatives.

Pain
[Mrs A] was reported to be in pain frequently and to be refusing to take the paracetamol at times. The RN was informed of this on 03/07/08.

Mood
[Mrs A's] fluctuating mood continued to be reported by care staff ranging from being tired and sleepy to agitated and aggressive particularly when staff provided hygiene procedures.

Weight
Her weight was recorded as 60 kgs on 3rd July. [Mrs A's] food intake was reported to be good. Occasionally she refused to eat. On the 27/07/08 Fortisip was recorded as having been given.

3.6.5 August 2008
Several assessments (gait and balance, depression, cognition, falls and pressure risk) were updated early in August by [Ms D]. The assessments indicated that [Mrs A] was mildly depressed, was low risk for pressure ulcers, and medium risk for falls. An evaluation was noted on these assessments. There is no documented evidence that the care plans were reviewed.

A bruise was reported on the right hip on 20th August and that [Mrs A] was barely walking. Bruising on the front and back of the right lower legs was reported by [Ms C].

On 20th August it was reported that [Mrs A] was refusing to take some of her medications and on August 23rd staff reported crushing her medications. Refusals to have showers/undress were being reported to be occurring more frequently.

On August 29th [Mrs A] complained of chest pain in the med sternum region. That afternoon she was tired and short of breath on exercise. [Mrs A] was reported to be feeling unwell in the days following this episode.

Skin
Care staff continued to report that the vulval/perineal rash was present. On August 6th 2008 it was reported Lemnis Cream was applied. The care plan stated that this could be applied to rashes PRN. On the 12/08/08 staff reported that she had developed a rash under her breast. Staff reported that the vulval/perineal rash was not improving.

On August 14th the GP prescribed Lamisil orally for one month for the breast and vulval/perineal rashes. On 17th August the rash was reported as not healing. By August 20th the rash was reported as less red. On August 30th staff reported that [Mrs A] had a vaginal discharge and on 30th August there was blood on the pad.

Bowels
There were no reports of loose bowel motions. Laxatives were being given.

Pain
Staff continued to report frequent episodes of pain particularly in the legs.

Mood

Aggressive episodes during personal hygiene cares were reported. Periods of wandering, agitation and sleepiness were being reported.

Weight
Weight was recorded as 58 kgs (no date documented), a loss of 2 kgs from the previous month. On the 08/08/08 the staff reported that [Mrs A] needed feeding. A report on August 25th indicated that her dentures were still missing.

3.6.6 September 2008
[Mrs A] went out on a van trip on September 15th and again on the 25th which she enjoyed.

On the 21st [Mrs A] was reported as not feeling well and wanted to stay in bed. Her leg/s was very sore. Her appetite was poor and her temperature was recorded as normal.

On September 25th following a van trip [Mrs A] was reported to be very pale and not responsive. Care staff reported that she could not lift her left foot to walk. She looked better once she was put back to bed. On September 26th [Mrs A] was very pale and tired. The care staff asked [Ms C] to see her. There is no evidence that [Ms C] assessed [Mrs A] at this time. Over the next two days reports indicated that [Mrs A] was more alert and eating in the mornings. However, in the afternoons she was again tired, sleepy, aggressive and not eating.

She was commenced on Citalopram on 27/09/08 by the NP. The rationale for this was not documented. She was reported to have had a good food and fluid intake. On September 28th care staff reported that [Mrs A] did not eat very much in the morning, was tired, sleepy and pale. She was put to bed and ate well in the afternoon. On September 29th she looked better and went on an outing in the van. She was very confused and aggressive later in the day. The next day care staff did not report any problems.

Skin
On the 02/09/08 staff reported that the vulval/perineal rash looked good, not red at all. A "discharge of blood" was reported with "no evidence of any injury". By September 6th the breast, vulval/perineal rashes had improved but were not totally healed. The course of Lamisil was completed on 12th September. The "rashes" were still present on September 19th. [Ms C] made an entry in the progress notes and on the care plan to use a cornflour paste on the rashes on the 30/09/08.

Bowels
There were no reports regarding bowel motions.

Pain
Care staff continued to record that [Mrs A] was in pain.

Mood
During September [Mrs A] fluctuated between having aggressive episodes, being sleepy and being alert. The NP was consulted regularly. The Risperidone dose was adjusted during the month by the NP. Episodes of aggression and sleepiness continued.

Weight
[Mrs A's] weight was recorded on 25/09/08 as 54 kgs. This was a loss of 4 kgs (6.8% of body weight) since the beginning of August. The reported episodes of refusing to eat or eating poorly increased.

3.6.7 October 2008

[Mrs A] went out again in the van on 3rd October and was happy on her return. Later that afternoon staff reported that [Mrs A's] mobility was very slow and she was very aggressive. On October 4th care staff reported that she had bruising on her arms.

On October 5th [Mrs A's] weight was recorded to be 50 kgs. On October 6th care staff reported [Mrs A] was very pale and not eating.

The GP saw [Mrs A] on 09/10/08 and noted the chest pain had resolved and charted "NLS" in the medical progress notes. This was not on the prescribing medication chart. Bloods were drawn on the 9th October. The GP stated that the urine was not offensive and the chest was clear and that the blood results indicated that she had an infection. The GP commenced a course of Augmentin on October 9th which was detailed in the medical progress notes but not on the medication prescribing chart. Augmentin was commenced on October 10th 2008.

On October 5th and 9th [Mrs A] was reported as frightened to walk. From the 9th October on, her walking, appetite and general health was reported to be worse. Care staff used a wheelchair to move her about. Care staff continued to get [Mrs A] out of bed.

[Mrs A] was reported to have enjoyed a van outing on the 10th October. She was reported to have a bruise on her right hand. Later that day staff report that [Mrs A] was very shaky and found it hard to stand, and staff used a lifting belt when moving her.

October 12th reports indicated that [Mrs A] was very tired, and was hard to understand. On the 13th October care staff reported that [Mrs A] was not responding and called [Ms C]. [Ms C] reported that she looked exhausted rather than having had a cerebral event. Care staff reported that [Mrs A] was quite frightened and looked very tired when being got up in the morning; she refused her medication but took it later in

the day; she had a late shower, and ate a little. Paracetamol was withheld ([Ms C's] documented orders in the progress notes). In the afternoon [Mrs A] ate soup and drank well, and said that moving any part of her body was painful. The night duty staff reported that she could not swallow much and she could not move any part of her body with even her hands staying in the original position.

On October 13th care staff reported paracetamol was withheld. Care staff noted that when they moved any part of her body she was sore. The night staff reported that she could not swallow much and that she could not move any part of her body and asked the nurse manager to see her. Care staff reported her face was red and the temperature was normal. [Ms C] documented that she checked on [Mrs A] and she was tired and that she had contacted the family. Her food intake was reported to be better in the morning but not the afternoon. She was reported to be drinking well. Care staff recorded that the nurse manager checked [Mrs A] on October 14th 2008 and that they had informed her that the "bowels were very runny". There was no entry in the progress notes by [Ms C]. Care staff reported that the groin and buttocks were very red.

Reports from the 15th October indicated that [Mrs A] had continuous loose bowel motions all night.

On October 16th 2008, [Mrs A] was reported to have been showered. There was a report of a skin tear on the left side of her hip.

[Mrs A] was transferred to [the private hospital] having been reassessed as hospital level care following a referral from reassessment made by the NP employed by [the] District Health Board and in agreement with the daughter.

Skin
There were no reports about skin rashes until October 14th when care staff reported the groin and buttocks were very red. A skin tear across the buttocks was reported and the nurse manager had been advised. Cornflour was reported to have been applied to the groin rash on October 15th. A skin tear on the left hip was noted on the morning of October 16th.

Bowels
On the 6th, 12th, and 14th to 16th she was reported to have had frequent loose bowel motions. On October 15th and 16th the loose bowel motions were reported to be non-stop.

Weight
She was reported to be eating well. On the 5th October [Mrs A's] weight was recorded as 50 kgs, down 4 kgs (7.4% of body weight) and 10 kgs down from the weight recorded on 25th September 2008 and 10 kgs down from the weight recorded in May 2008 (16.6% of body weight).

Pain
[Mrs A] was reported to always be saying "her legs were very sore". On October 13th care staff reported paracetamol was withheld. From this date care staff noted that when they moved any part of her body she was sore.

Mood
From the 4th October [Mrs A] was reported to be continually tired and sleepy with ongoing episodes of aggression. [Mrs A] was reported to have been hitting a staff member who was trying to change her.

On Admission to [the private hospital]
During the admission assessment completed by the RN at [the private hospital], the RN identified skin conditions that were of concern. The family consented to photographs being taken of the affected areas. The photographs revealed serious skin excoriation extending from above the anus through the groin area and spreading onto the buttocks (see page 00005), a broken area of skin on the left hip area, and large black areas with associated blistering on both heels. In addition the photographs indicated bruising on both lower legs and on the bottom of the right foot (see page 00006).

Entries in [the private hospital] progress notes indicated the loose bowel motions continued and they queried impaction as a possible cause for this.

Section 4
4.0 Findings
4.1 Findings in relation to [Mrs A's] care 1/04/08 to 16/10/08
The documentation of observations and care over the period in question was entered into the progress notes. The entries were not made every day until 25/09/08. In the main most of these entries appear to have been made by the care givers. [Ms C] made six entries (25/06/08, 27/08/08, 26/09/08, 30/09/08, 9/10/08, and 13/10/08). In addition, [Ms C] recorded the time and date of discharge in the progress notes. There were no entries that could be clearly identified as being made by [Ms D]. There was one entry on the care plans during the period in question made by [Ms C] on 30/09/08 regarding skin care.

[Mrs A's] general condition appeared to be relatively stable 1st April to July 2008. More health issues were reported in August (refer to 3.6.5) and September 2008 (refer to 3.6.6). Between September 21st and 16th October 2008 (refer to 3.6.7) care staff reported increasing health problems. The GP diagnosed an infection based on diagnostic tests on October 9th 2008. The deterioration in [Mrs A's] health escalated from this point on. There were problems reported during the period in question including:

- ability to stand and walk
- pain
- loose bowel motions
- declining appetite and significant weight loss

- medication management issues e.g. not taking pain relief and crushing medications that should not be crushed, withholding pain relief, no evidence of review of the success of new treatments
- a fall, bruising on limbs and skin tears on buttocks
- episode of chest pain
- skin rashes/excoriation that resolved but returned
- mood fluctuations from sleepiness to anxiety/wandering to agitation to aggression
- increasing tiredness and feeling unwell
- increasing health issues in between the 9th October, the last consultation with the GP, and the 16th October

There is little documented evidence of the responses by the RNs, [Ms D] and [Ms C] to these problems. There may well be documentation in the communication books that were used at Belhaven Rest Home. However, these are not part of the documentation supplied.

From October 9th when the GP last saw [Mrs A] there is documented evidence of a rapid decline in her health with no documented evidence of responsiveness by the nurse manager, [Ms C], who at the time was also undertaking the responsibilities of the RN. There was no documented evidence that [Mrs A's] deteriorating condition was discussed with her GP from the 9th October onwards. [Ms C] recorded seeing [Mrs A] on October 13th , 2008 when care staff reported [Mrs A] was very unwell. I cannot find documented evidence that she contacted the GP. There is evidence that she contacted the family.

The documented evidence indicates that the care staff were providing the following: meals, fluid, hygiene procedures, topical treatment to the rashes and assistance with mobility. The entries were not daily therefore I cannot state that the care plans were followed every day and on every shift. The medication signing sheets confirm that prescribed oral medications were given.

It is my opinion that [Ms C], [Ms D] and Belhaven Rest Home did not ensure that the standard of care that [Mrs A] could expect occurred. This is more serious in the case of [Ms C]. In the last three weeks of [Mrs A's] stay at Belhaven, [Ms C] provided no documented evidence that she had assessed and identified the seriousness of [Mrs A's] deterioration, had adjusted the care accordingly or consulted adequately with the GP. As the nurse manager, [Ms C] had a responsibility under the ARRC service provider agreement to ensure that [Mrs A] was adequately cared for in respect of her everyday needs, and did not do so.

4.1.1 Assessment and care planning

There is evidence of fall risk, depression, cognitive function, and gait and balance assessments being updated by the RN, [Ms D], in early August. There is no documented evidence that care plans were reviewed between 1st April and 16th October 2008 apart from one entry made by [Ms C], the nurse manager, on the 30th September relating to treatment of the rashes. The care plans had not been reviewed since November 2007.

As set out in the summary of [Mrs A's] care it is evident that there were numerous problems (loose bowels motions, pain, mood swings, weight loss, skin integrity problems, tiredness, feeling unwell, declining mobility and function) that [Mrs A] was suffering. There was no evidence in the assessments or care plans to indicate that these problems had been identified and addressed.

[Ms D] stated in her letter and during an interview that the Nurse Manager, [Ms C], said that she would update the care plans. The RN position description in use at Belhaven Rest Home at that time clearly indicated that the responsibility of the assessment and care planning was [Ms D's]. Therefore, [Ms D] had a responsibility to ensure that the assessments were completed and care plans were reviewed during her employment at Belhaven.

[Ms C] also had a responsibility to review care plans in the absence of [Ms D], e.g., during the school holidays when [Ms D] did not work, after hours and on the weekends. At some point [Ms D's] days were reduced from five days a week to three days so [Ms C] had a responsibility for assessments and to update the care plans on the days [Ms D] did not work. From September 25th, the responsibility was solely with [Ms C]. There is no evidence to support [Ms C] having done so.

[Ms C], as Manager, had a responsibility to ensure that the organisation's policies and procedures were correctly implemented. The evidence indicated that this did not occur.

Belhaven Rest Home also had a responsibility to ensure that the relevant standards were being met.

It is my opinion that both [Ms D] and [Ms C] failed to ensure that the standards (refer to section 2) required for assessment and care planning were met, and that Belhaven Rest Home did not have systems in place to ensure compliance with the standards.

4.1.2 Documentation

Although [Ms D] and [Ms C] stated during interviews and in written responses that [Ms D] and [Ms C] gave instructions related to [Mrs A's] care, it was not evident in the clinical record. Registered Nurse peers would expect the clinical notes to tell the whole story about [Mrs A's] care, show the RN observations and how she acted on them, show continuity of care, show care delivered following her evaluations, and show how [Mrs A] responded to care and medications and other treatments (New Zealand Nurses Organisation, 1998a). As part of effective communication and follow-up, an RN would be expected to read the documentation by all care staff and document her actions in response to problems identified by the care staff. Belhaven's procedure for the progress notes stated that "the RN shall follow up on any documentation".

The relevant standard (refer to Section 2) requires that the clinical records are integrated, therefore documenting clinical information outside the clinical record, e.g. in a communication book, is not acceptable practice.

The author of any documentation in the clinical record must be identifiable. Further, Belhaven's guidelines for documentation (page 00208) stated that entries in the progress notes were to be signed, then the name printed and designation documented. Most entries in the progress notes were not identifiable. [Ms C's] entries in the progress notes were identifiable and designated, [Ms D's] were not. [Ms C], as Manager, had a responsibility to ensure that the organisation's policies and procedures were correctly implemented. The evidence indicates that this did not occur. Belhaven Rest Home also had a responsibility to ensure that the relevant standards were being met.

It is my opinion that both [Ms D] and [Ms C] failed to ensure that the standards (refer to section 2) required for documentation were met, and that Belhaven Rest Home did not have systems in place to ensure compliance with the standards.

4.1.3 Skin care

[Mrs A] was troubled with skin problems that were described by staff in a number of ways in the progress notes. There were rashes/excoriation on the vulval and perineal areas, the buttocks and under the breasts. The rash under the breasts developed in August 2008. The rashes/excoriation in the other areas will be referred to as "the skin rash". The skin rash was first documented in April 2008 and was an ongoing problem until discharge. [Mrs A] was reported to have complained frequently that the skin rash area was very itchy.

The Belhaven Rest Home wound management procedures specify that skin problems will have a care plan and that the RN will follow up and sign off when the wound is healed. There was no evidence of a care plan for the skin rash until the 30th September 2008 when [Ms C] updated the care plan for the use of cornflour. There is little documented evidence of how the skin rash was managed up until July 24th 2008. There were entries in the progress notes that indicate other treatments may have been used, such as Lemnis fatty cream during the time Pimafucort ointment was prescribed. There is no documented evidence of RN ongoing assessment and evaluation of the response to treatment.

The first indication that the rash was seen by the GP was on 24th July when Pimafucort ointment was prescribed in the medical progress notes. Pimafucort ointment was not prescribed on the medication chart. The care plan stated that topical treatments charted would be signed for on the medication chart. There is no evidence on the medication chart that the Pimafucort was applied. There is no documented evidence of how long or how frequently Pimafucort was used.

The progress notes reflected the ongoing state of the skin rash. Oral Lamisil was commenced on August 14th 2008. There appeared to have been some degree of success with the oral therapy of Lamisil as the rash was recorded by care staff as being nearly healed on September 6th, 2008. However, there is no documented evidence to suggest that the skin rash healed completely. The next report relating to the skin rash was October 14th 2008 when care staff reported that the groin/buttocks were red. The care staff reported that the skin rash was present on the day of discharge. There is no documented evidence that [Ms D] or [Ms C] assessed the rash

or consulted the GP about the skin rash after the completion of the course of oral Lamisil.

While there was a lack of documentation regarding the care required for the skin rash it was evident that daily to twice daily showers were being carried by the care staff when possible, that efforts were being made to resolve the rashes and that the GP was consulted. Such skin conditions can be extremely difficult to diagnose and resolve. However, there was no documented evidence that the possible range of causative factors had been considered. These may have included an allergic response to the disposable continence products used, contact dermatitis, use of soap and medications, and the continuing loose bowel motions. Tamoxifen may have been linked to the itchiness and vulval rash as its adverse effects include genital organ pruritus, skin rash and vaginal discharge.

The skin rash present at the time of discharge (page 00005) was of a serious nature and would have caused considerable discomfort to [Mrs A].

While such skin rashes may be difficult to diagnose and resolve, and there was evidence of consultation with the GP, it is my opinion that both [Ms D] and [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of the skin rash. [Ms C] prescribed cornflour paste. I have not been able to locate any evidence-based practice that supports this as a treatment option. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for assessment, care planning, and evaluation, or the adherence to its own policies and procedures.

4.1.4 Pressure Ulcers

The pressure ulcers in the photographs taken on arrival at [the private hospital] were at least stage three ulcers. There was blistering present that indicated that the development of the pressure ulcers was reasonably recent. These ulcers would have caused [Mrs A] considerable discomfort. The ulcers probably developed once [Mrs A] stopped moving, in the last 3 to 4 days of her stay at Belhaven. There was no documented evidence in the progress notes of any pressure ulcers.

When [Mrs A] became so unwell that she could not move, her risk for pressure ulcers should have been reviewed and the care plan updated. There is no documented evidence that this occurred. If the care givers had been instructed to turn [Mrs A] more frequently, keep the pressure off her heels, and pressure-reducing surfaces put into place these ulcers could have been avoided (Standards New Zealand, 2005).

I note that Belhaven Rest Home's policy stated that pressure ulcers do occur in rest homes. The Handbook; SNZ 8163:2005 Indicators for safe aged-care and dementia-care for consumers indicates that industry experts agree that the development of pressure ulcers in residential care is below the standard of care expected and set a zero target for pressure ulcer rates.

The policy required that the RN complete appropriate assessment and record instructions in the care plan. No care plan was provided as evidence that included instructions for pressure ulcer prevention. There was one entry in the progress notes

about 2-hourly turns, which appeared to have been written by a care giver. [Mrs A's] risk of pressure ulcer development was assessed by [Ms D] in August 2008 as being low.

[Mrs A] was slowly mobile at this time and had not lost a substantial amount of weight; therefore, the care plans for activities of daily living were sufficient at that time. However, as [Mrs A's] condition deteriorated and she lost a substantial amount of weight, the care plan was no longer adequate.

It is my opinion that [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of [Mrs A's] deteriorating health and pressure ulcer risk in the last week [Mrs A] was a resident at Belhaven Rest Home. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for assessment, care planning, and evaluation, or the adherence to its own policies and procedures.

4.1.5 Loose bowel motions

While there is evidence that loose bowel motions were an ongoing problem, any actions taken by the RNs to assess the problem and resolve it were absent from the documentation provided. It is likely that the laxatives and/or faecal impact were responsible for this ongoing problem. In the last week the antibiotic Augmentin may have contributed to the problem of the loose bowel motions. The loose bowel motions may have contributed to the level of excoriation associated with the groin/buttock rash at the time of discharge. [Mrs A's] bowel movement record was requested from Belhaven but they were unable to supply it.

It is my opinion that [Ms D] and [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of [Mrs A's] bowel motions. This was a serious failure in the case of [Ms C] over the last week of [Mrs A's] stay at Belhaven Rest Home when she had obviously developed diarrhoea. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for assessment, care planning, and evaluation, or the adherence to its own policies and procedures.

4.1.6 Pain management

As early as the 27/4/08, staff reported that [Mrs A] was verbalising being a bit sore in the left leg. Ongoing pain management issues were reported in the progress notes. The last documented pain assessment was on the 14/11/07. This assessment indicated that [Mrs A] was generally pain free. In May, 2008 paracetamol was packed into the blister packs so that it was to be routinely given rather than as needed. The care plan was not updated to reflect this. When paracetamol was prescribed routinely there was not documented record of the positive and/or negative effects of this change or that they were made known to the prescriber.

The progress notes indicate that [Mrs A] was refusing to take the paracetamol from July onwards and was in pain. The pain was such that it was reported to affect her ability to walk. In the last three days of her stay at Belhaven Rest home [Mrs A's] pain appeared to be a major problem. At this time, although staff reported that [Mrs A] was in pain, [Ms C] ordered the paracetamol to be withheld. [Mrs A's] daughter stated that [Mrs A] was complaining of significant levels of pain.

Some of the behaviours that [Mrs A] presented with may have been related to pain, such as the aggression and sleepiness. With [Mrs A] having a diagnosis of breast cancer, monitoring her closely for pain would be considered by nursing peers as fundamental to meeting [Mrs A's] needs.

It is my opinion that [Ms D] and [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of [Mrs A's] pain. This was a serious failure in the case of [Ms C] over the last week of [Mrs A's] stay at Belhaven Rest Home when she obviously had significant levels of pain and [Ms C] ordered the paracetamol to be withheld. Nor did [Ms C] consult with the GP regarding [Mrs A's] pain. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for assessment, care planning, and evaluation or the adherence to its own policies and procedures.

4.1.7 Mobility

[Mrs A] was reported to be mobile but slow. She used a walking frame but at times needed to be reminded to use it. [Mrs A] had had a fall and was known to wander at times. There were updated assessments for gait and balance, and a falls risk was completed by [Ms D] in August 2008. An evaluation dated 03/08/08 where it was indicated that mobility needs remained the same. It appeared that [Mrs A] maintained mobility at this level until 29/08/08.

On August 29th 2008 [Mrs A] suffered chest pain in the morning, and in the evening was reported to be very tired when walking, and was breathless if she walked too much. While she appeared to recover from this episode her mobility continued to deteriorate. The care staff reported that she was having difficulty standing and walking. Care staff reported the need to use a wheelchair in September 2008. During the last week that [Mrs A] resided at Belhaven Rest Home, care staff reported that she was barely able to move. There was no evidence in the documentation provided that her mobility was reassessed or that the care plan has been updated.

It is my opinion that [Ms D] and [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of [Mrs A's] mobility. This was a serious failure in the case of [Ms C] over the last week of [Mrs A's] stay at Belhaven Rest Home when she obviously had significant mobility issues. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for assessment, care planning, and evaluation, or the adherence to its own policies and procedures.

4.1.8 Weight loss

[Mrs A's] weight was stable from April 1st until August (date not known) with a 2 kg loss recorded — 3 percent of her body weight. Even though there was a recorded weight loss, the next recorded weight was not until September 29th 2008. While weight loss frequently occurs as a person enters the end stage of dementia, it should be closely monitored and responded to. Between August and October 5th a loss of 8 kgs was recorded — 13.8 percent of her body weight. This level of loss was significant and should have resulted in further assessment and review of the care plan. No evidence has been provided that this occurred. Weight loss of this level would normally result in a referral to a dietician (Standards New Zealand, 2005).

[Mrs A] was on a number of medications known to affect appetite/cause nausea. In addition pain was likely to have affected her appetite.

The care staff reported changes in [Mrs A's] intake. Staff reported that they were feeding [Mrs A] at times and that she was refusing to eat at some meal times. The progress notes indicated that care staff gave [Mrs A] Fortisip on at least one occasion. [Ms D] indicated in her statement that [Mrs A] was given Fortisip routinely. This was not recorded in the evidence provided. There was not an updated assessment or changes made to the care plan to address [Mrs A's] changing nutritional status.

It is my opinion that [Ms D] and [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of [Mrs A's] nutritional needs. This was a serious failure in the case of [Ms C] over the last three weeks of [Mrs A's] stay at Belhaven Rest Home when she obviously had significant weight loss and care staff reported that [Mrs A] was not eating. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for assessment, care planning, and evaluation, or the adherence to its own policies and procedures.

4.1.9 Medications

There have been issues identified in section three with the medication management for laxatives, topical treatments and short course medications. All prescribed medications must be prescribed on the medication record. There was a query by the GP that Lamisil was not commenced on the day it was prescribed (14/8/08). The records indicate that the first dose was given at 0915 on 15/08/08. Augmentin was prescribed on the 9th October; the first dose was given on the morning of 10th October. In the event of a life-threatening infection, this delay could have resulted in the death of the resident.

Care staff reported crushing medications. There was a handwritten unsigned instruction to do so on the medication prescribing sheet (Pages 00244 and 00245). There were clear instructions for two medications to be swallowed whole as part of the prescribing by the GP — therefore the instruction to crush these medications, Span-K and Aspirin, was unsafe. The medication signing sheets indicated that the RN was checking medication administration weekly. However, the RN signatures for August 2008 (Page 00255) are not identifiable. The care staff practice of crushing medications that were clearly labelled to be taken whole should have been addressed by [Ms D] or [Ms C] when undertaking the routine weekly checks of the medication sheets.

There were a number of problems identified in relation to medication management:

- the lack of a documented review of pain management when in May 2008 paracetamol was prescribed routinely and when staff consistently reported that [Mrs A] had pain
- the lack of review of the effectiveness of Nozinan prescribed on 23/05/08 after which the first aggressive episode was reported
- the lack of review of the effectiveness of Celapram 20 mg prescribed on 26/09/08 and started 27/09/08

- identification of possible side effects of medications such as Tamoxifen
- the use of laxatives without adequate documented review when episodes of loose bowel motions were being reported
- crushing of medications that should be swallowed whole
- correct charting of prescribed medicines
- signing for all prescribed medicines including topical medications

When new medication is prescribed or there are changes to doses of medications, an RN is expected to record the positive and/or negative effects of this and make them known to the prescriber (page 22) (New Zealand Nurses Organisation, 2007). I was unable to find evidence that this had occurred.

It is my opinion that [Ms D] and [Ms C] failed to ensure that medication management met the required standards (refer to Section two). Belhaven Rest Home did not have systems in place to ensure compliance with the standards of medication management.

4.1.10 Mood and behaviour management

[Mrs A's] mood/behaviour fluctuated from being tired and sleepy to agitated and aggressive. Most aggressive episodes occurred when personal/hygiene cares were being provided. There is not documented evidence of behaviour assessment. The identification of the triggers of the behaviours and a revised care plan to assist staff to manage the increasing aggression was not evident.

There was evidence of ongoing consultation regarding the aggression with the NP from the District Health Board. While specialist consultation was evident, there were gaps in the assessment and care planning, particularly in relation to the episodes of aggressive behaviour that may have put the resident and/or other residents at risk.

It is my opinion that both [Ms D] and [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of the mood swings. This was a serious failure in the case of [Ms C] over the last three weeks of [Mrs A's] stay at Belhaven Rest Home when she obviously had significant aggressive episodes and significant periods of sleepiness. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for assessment, care planning, and evaluation, or the adherence to its own policies and procedures.

4.1.11 Incident reporting

There are numerous incidents reported in the progress notes that have not been documented on an incident form including:

12/05/08 bruise on right foot
26/5/08 incident of aggression between 2 residents
22/08/08 aggression hitting staff
24/08/08 aggression
27/08/08 bruising to right lower leg
28/08/08 aggression
01/09/08 bruises on both left and right hands
10/09/08 aggression

12/09/08 aggression hitting staff
26/09/08 aggression hitting staff
29/09/08 aggression hitting staff
2/10/08 aggression with another resident and aggressive during the night hitting staff
3/10/08 aggression
04/10/08 bruising both arms
5/10/08 aggression x 2
10/10/08 bruise on right hand
16/10/08 bruising on legs at time of discharge

When incidents were reported there was little documented evidence provided of investigation and corrective action plans. The standards required that all incidents are reported, investigated and corrective action taken.

While [Ms D] stated in an interview that she requested the GP to see the facial bruising of an incident reported on 24/06/09 the next recorded GP visit was 27/07/08.

It is my opinion that [Ms C], as manager, failed to ensure that all incidents were documented, that there was adequate investigation of these incidents or that corrective action plans were developed as required by the standards (refer to section two). Belhaven Rest Home did not have systems in place to ensure compliance with the standards for risk management.

4.1.12 Communication

Throughout the progress notes there is evidence of events and changes in care that should have been communicated to the family. There is little documented evidence provided that there was any communication with the family. [Ms C] did contact the family when [Mrs A] had chest pain in August 2008 and again on October 13th 2008 when [Mrs A] was reported to be unwell. This was confirmed by [Mrs A's] daughter.

A meeting was held to discuss the need for a change in the level of care which the daughter and the NP attended. This meeting was organised by the staff of [the] District Health Board.

The GP records indicate that a medical care review was undertaken on 22/05/08 and again on 14/8/08 where treatment was altered. There is no documented evidence of who attended or if there was discussion with the family. A family communication sheet (page 00294) was provided. The last entry on this sheet was 30/10/07. An RN review sheet (page 00295) was also provided. The last entry on this sheet was 14/11/07.

It is my opinion that [Ms D] and [Ms C] failed to ensure that there was adequate communication with [Mrs A's] family. This was a serious failure in the case of [Ms C] over the last three weeks of [Mrs A's] stay at Belhaven Rest Home when she obviously had significant health issues. Belhaven Rest Home did not have systems in place to ensure compliance with the standards for communication with residents/families (refer to section two).

Section 5

5.0 Findings in relation to [Ms D], registered nurse

5.1 Responsibilities

[Ms D] was employed as the RN between 1/04/08 and 25/09/08 when she resigned. She worked Monday to Friday 0830 to 1500 hours and was not expected to take calls outside these hours. She did not work school holidays or weekends. Following a managers' meeting [Ms D's] hours were reduced to three days a week. The date of this change was not provided. [Ms D] acknowledged that she had 30 years of nursing experience.

As the registered nurse, [Ms D] was responsible to the nurse manager, [Ms C]. [Ms D's] responsibilities included:

- comprehensive care planning for each resident
- providing and supervising care of residents
- ensuring safe, efficient and therapeutically effective care
- when requested making professional, safe assessments of the requirements for residents
- maintenance of the clinical records and written communication to staff
- advising on care and administration of medication ensuring that staff had an understanding of the side effects of the medications administered.
- effectively communicating with the manager

5.2 Did [Ms D] provide an appropriate standard of nursing assessment and care to [Mrs A]?

It is my opinion that [Ms D] did not ensure that the standard of care that [Mrs A] could expect occurred.

5.2.1 Assessment, care plans and evaluation of care

Based on the evidence provided, in my opinion [Ms D] failed to ensure that adequate, ongoing assessments, reviews and updating of care plans and evaluation of care occurred. Subsequent information provided in letters and interviews does not change this opinion. [Ms D's] peers would view her conduct with moderate disapproval.

5.2.2 Documentation

It is my opinion that [Ms D] did not meet the standards required for documentation including incident reporting as presented in the findings above. [Ms D] did not adhere to Belhaven's guidelines or to the required standards. In addition, [Ms D's] peers would expect the communication in the clinical record to tell the whole story about [Mrs A's] care, show her observations and how she acted on them, show continuity of care, show care delivered following her evaluations and show how [Mrs A] responded to care and medications and other treatments (New Zealand Nurses Organisation, 1998a), and entries in the clinical record to be identifiable to the person who wrote them by the use of a signature and title (New Zealand Nurses Organisation, 1998a). [Ms D's] peers would view her conduct with severe disapproval.

5.2.3 Nutrition and weight loss

There is no evidence that [Ms D] ensured that [Mrs A] was weighed regularly. Nor was there evidence that the assessment and care plan were updated when care staff reported that [Mrs A] was not eating as well or when her dentures were missing. The failure by [Ms D] to assess, review and update the care plan at the beginning of August when a small weight loss was identified may have contributed to the significant weight loss during August and September 2008. [Ms D's] peers would view this with moderate disapproval.

5.2.4 Personal hygiene and mobility

The care staff documentation in the progress notes provided evidence that personal care was being provided consistently. [Mrs A] maintained mobility until 29/08/08. After this time the care staff reported difficulties mobilising [Mrs A]. Gait, balance and falls risk assessments completed on 8/8/08 indicated that the plan of care for mobility was current. However, her mobility deteriorated after 29/08/08. It is my opinion that [Ms D] failed to ensure that there was ongoing assessment, care planning and evaluation of [Mrs A's] personal care needs and mobility. [Ms D's] peers would view this with moderate disapproval.

5.2.5 Skin integrity

[Mrs A] had problems with skin rashes during [Ms D's] employment at Belhaven Rest Home. There was consultation with the GP, and the rashes did resolve for periods of time. Because of the substandard documentation I was not able to establish the full picture of the treatment and progress. In the case of [Ms D] there is some evidence that the skin rashes were treated. Further, there is no evidence that pressure ulcers had developed during [Ms D's] employment as the RN at Belhaven Rest Home. [Ms C] took over the responsibility for wound care from [Ms D] at some point (date not confirmed).

It is my opinion that [Ms D] failed to ensure that there was ongoing assessment, care planning and evaluation of the skin rash. In my opinion [Ms D] has no case to answer regarding pressure ulcers. In regards to the skin rash, [Ms D's] peers would view this with mild disapproval.

5.2.6 Mood swings/behaviour management

While specialist consultation was evident regarding aggressive behaviour and sleepiness, there were gaps in the assessment and care planning particularly in relation to the identifying triggers of the aggressive behaviour. The care plans were not updated when the aggressive behaviour became a problem. The NP did adjust medications.

In my opinion [Ms D] failed to provide evidence of ongoing assessment and review of the care plans as aggressive behaviour increased. [Ms D's] peers would view her conduct with moderate disapproval.

5.2.7 Pain management

[Mrs A] was at times in pain during [Ms D's] employment at Belhaven Rest Home. [Ms D] had a responsibility to assess and review the plan of care in relation to pain

and to refer to the GP if pain was ongoing. Because of the substandard documentation I was not able to establish that this had occurred.

It is my opinion that [Ms D] failed to ensure that there was ongoing assessment, care planning and evaluation of [Mrs A's] pain. [Ms D's] peers would view her conduct with moderate disapproval.

5.2.8 Medication management

The medication management did not meet the required standards. The crushing of medications that should be taken whole was an unsafe practice. It was [Ms D's] responsibility to provide advice on the administration of medication ensuring that care staff had an understanding of the side effects of the medications administered. Nor did [Ms D] provide evidence that she evaluated the response to new medication or changes to medications. Medications prescribed by the GP in the medical progress notes were not always prescribed on the medication prescribing chart. Laxatives were being given but they were not prescribed on the medication prescribing chart by the GP.

It is my opinion that [Ms D] failed to ensure that medication management met the required standards (refer to Section two). [Ms D's] peers would view this as a severe failure.

5.3 Did [Ms D] communicate appropriately with [Mrs A's] family?

There was no documented evidence that [Ms D] communicated with [Mrs A's] family. There appeared to be confusion as to who assumed the role for communicating with the family. Further, I note that the position description did not require [Ms D] to communicate with families. However, it is within the scope of practice of all registered nurses (Nursing Council of New Zealand, 2007). It is my opinion that [Ms D] failed to ensure that there was adequate communication with [Mrs A's] family. [Ms D's] peers would view this with moderate disapproval.

Section 6

6.0 Findings in relation to [Ms C], Nurse Manager

[Ms C] was employed as the nurse manager between 08/04/08 and 16/10/08. From the 25/09/08 [Ms C] undertook the role of registered nurse in addition to being the nurse manager. She worked Monday to Friday, and expected to take calls outside these hours. She covered the responsibilities of the registered nurse when [Ms D] was not on duty.

As the nurse manager [Ms C] was responsible to the Directors, Belhaven Rest Home. [Ms C's] responsibilities included:

- strategic development
- meeting directors' requirements
- financial management
- quality of service delivery including oversight of the clinical environment, appropriate levels of 24-hour care being delivered to meet the residents' needs, and evaluation of services provided

- effective leadership and development of staff including support and feedback to all staff
- compliance with legal and contractual requirements
- continuous quality improvement
- health and safety

6.1 In the absence of [Ms D] did [Ms C] provide an appropriate standard of nursing assessment to [Mrs A]?

It is my opinion that [Ms C] did not ensure that the standard of care that [Mrs A] could expect occurred. In the last three weeks of [Mrs A's] stay at Belhaven, during which time [Ms C] was the RN, there was no documented evidence provided to support that she had adequately assessed and identified the seriousness of [Mrs A's] deterioration, had adjusted her care accordingly or consulted adequately with the GP. As the nurse manager [Ms C] had a responsibility under the ARRC service provider agreement to ensure that [Mrs A] was adequately cared for in respect of her everyday needs, and did not do so. [Ms C's] peers would regard this with severe disapproval.

6.1.1 Assessment, care plans and evaluation of care

In my opinion, with the evidence provided, [Ms C] failed to ensure that adequate, ongoing assessments, updating of care plans and evaluation of care were carried out between 1/04/08 and 16/10/08 in the absence of [Ms D] to the required standard (refer to Section two). Subsequent information provided does not change this opinion.

There were no documented assessments completed by [Ms C] provided as part of the evidence. The care plans had not been reviewed since November 2007. [Ms D] stated in her letter and during an interview that the Nurse Manager, [Ms C], would update the care plans. [Ms C] confirmed this. Therefore [Ms C] had undertaken the responsibility for care planning and should have ensured that the care plans were updated. [Ms C] had also indicated that she would be responsible for all wound care.

The progress notes provide evidence that [Mrs A] was becoming more dependent and having ongoing issues with loose bowel motions, pain, mood swings, weight loss, skin integrity problems, and declining mobility, which needed to be reflected in the care plans. There was a progressive and significant deterioration in the three weeks from 25/09/08 to 16/10/08. Following the diagnosis by the GP of the presence of an infection, [Ms C] did not review [Mrs A's] care needs or provide instructions to care staff regarding her increasing care needs or whether she was well enough to go out in the van. The entries made in the progress notes by [Ms C] do not provide any reassurance that [Ms C] had identified the seriousness of [Mrs A's] condition or that she consulted the GP after October 9th 2008. [Ms C's] peers would view her conduct with severe disapproval.

6.1.2 Documentation

It is my opinion that [Ms C] did not meet the standards required for documentation including incident reporting as presented in the findings in section four. [Ms C] did not adhere to Belhaven's guidelines. The entries made in the progress notes by [Ms C] were identifiable.

[Ms C's] peers would expect the communication in the clinical record to tell the whole story about [Mrs A's] care, show her observations and how she acted on them, show continuity of care, show care delivered following her evaluations, and show how [Mrs A] responded to care and medications and other treatments (New Zealand Nurses Organisation, 1998a). [Ms C's] peers would view her conduct with severe disapproval.

6.1.3 Nutrition and weight loss

Significant weight loss was reported on September 25th 2008. This was the date that [Ms C] took over the role of RN after the resignation of [Ms D]. There is no evidence that [Ms C] assessed [Mrs A], or consulted the GP, NP or a dietician regarding this, or reviewed the care plans. The magnitude of the weight loss was a clear indication of [Mrs A's] deteriorating health. [Ms C's] peers would view her conduct with severe disapproval.

6.1.4 Medication management

There were a number of problems identified in relation to medication management. The crushing of medications that should be taken whole was an unsafe practice. It was [Ms C's] responsibility to provide advice on the administration of medication ensuring that staff had an understanding of the side effects of the medications administered. Nor did [Ms C] provide evidence that she evaluated the response to new medications or changes to medications. The continued use of laxatives when episodes of loose bowel motions occurred was not reviewed. Medications prescribed by the GP in the medical progress notes were not always prescribed on the medication prescribing chart. Laxatives were being given but they were not prescribed on the medication prescribing chart by the GP.

It is my opinion that [Ms C] failed to ensure that medication management met the required standard (refer to section two). [Ms C's] peers would view her conduct with severe disapproval.

6.1.5 Skin integrity

[Ms C] took over the responsibility for wound care from [Ms D]. [Mrs A] had problems with skin rashes (excoriation) during the period in question. There was consultation with the GP, and the rashes did resolve for periods of time. Because of the substandard documentation I was not able to establish the full picture of the treatment and progress. In the case of [Ms C] there is insufficient evidence that the skin rashes were being treated from September 15th until 16th October 2008. [Ms C] prescribed cornflour paste on September 30th 2008. I have not been able to locate any evidence-based practice that supports this as a treatment option.

There is evidence that [Mrs A] had become completely dependent and was not moving herself in the last two days she resided at Belhaven Rest Home. There is no evidence that [Ms C] assessed the level of risk for developing pressure ulcers or reviewed the plan of care and instructed the care staff in pressure ulcer prevention. Had [Ms C] done so, it is unlikely that the pressure ulcers would have developed. The fact that there were blisters covering what appears to be at least stage three ulcers indicated that the pressure ulcers had developed close to the discharge on the 26th

October 2008. It is my opinion that [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of the skin rash and pressure ulcer risk. [Ms C's] peers would view her conduct with severe disapproval.

6.1.6 Mood swings/behaviour management

While specialist consultation was evident regarding aggressive behaviour and sleepiness, there were gaps in the assessment and care planning, particularly in relation to the identifying triggers of the aggressive behaviour. The care plans were not updated when the aggressive behaviour became a problem. The NP was consulted and did adjust medications.

It is my opinion that [Ms C] failed to ensure that there was ongoing assessment, care planning and evaluation of the mood swings. This was a serious failure in the case of [Ms C] over the last three weeks of [Mrs A's] stay at Belhaven Rest Home when she obviously had significant aggressive episodes and significant periods of sleepiness. The magnitude of the behaviour issues was a clear indication of [Mrs A's] deteriorating health and the pain she was in. It is acknowledged that the NP was being consulted and was visiting regularly. However, [Ms C] did have a responsibility to ensure that the care plan for [Mrs A] maximised the safety of [Mrs A], other residents and the staff. [Ms C's] peers would view her conduct with moderate disapproval.

6.2 Did [Ms C] communicate appropriately with [Mrs A's] family?

There appeared to be confusion between [Ms C] and the directors as to who assumed the role for communicating with the family. However, it is clearly the role of the RN to communicate with the family in relation to clinical matters. In my opinion there was documented evidence that [Ms C] communicated with [Mrs A's] family on two instances, August 2008 and October 13th 2008. It is my opinion that [Ms C] failed to ensure that there was adequate communication with [Mrs A's] family at other times. This was a serious failure in the case of [Ms C] over the last three weeks of [Mrs A's] stay at Belhaven Rest Home when she obviously had significant health issues. [Ms C's] peers would view this as a severe failure.

6.3 Did [Ms C] take appropriate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mrs A]?

It is my opinion that [Ms C] did not ensure that the standards of assessment and care that [Mrs A] could expect occurred. This is more serious in the case of [Ms C] in the last three weeks of [Mrs A's] stay at Belhaven, during which time [Ms C] provided no documented evidence that she had assessed and identified the seriousness of [Mrs A's] deterioration, had adjusted her care accordingly or consulted adequately with the GP. As the nurse manager, [Ms C], had a responsibility under the ARRC service provider agreement to ensure that [Mrs A] was adequately cared for in respect of her everyday needs, and did not do so. [Ms C's] peers would view this as a severe failure.

Section seven

7.0 Findings in relation to Belhaven Rest Home

7.1 Adequate clinical governance and quality structures in place

Belhaven Rest Home failed to provide adequate clinical governance and quality assurance structures.

If adequate clinical auditing and risk management had been in place then the issues with clinical effectiveness, documentation, assessment and care planning, and medication management would have been identified and addressed. The issues-based audit undertaken by [the] District Health Board in March 2009 indicated that the issues present at the time of the complaint were ongoing as evidenced by the number of moderate risk partial attainments.

The aggressive episodes were a risk to other residents, staff and to the organisation, yet very few of these episodes were documented on an incident form. Resident injuries such as bruising were inconsistently reported on an incident form.

In my opinion Belhaven Rest Home was not meeting the Health and Disability Sector Standards for quality and risk management at the time of the complaint. Belhaven Rest Home's peers would view this with moderate disapproval.

7.2 Was [Ms C] adequately supported?

[Ms C], as nurse manager, was delegated all functions required by the Ministry of Health and [the] District Health Board — financial management, human resource management and the quality of service delivery. [Ms C] reviewed policies and procedures. The directors were available on site or by phone. However, there were no formal meetings or reporting of quality/risk matters such as incidents. No performance appraisal was completed. In my opinion support was available to [Ms C]; however, the structure was informal and therefore it was not robust. Belhaven Rest Home's peers would view this with mild disapproval.

7.3 Was [Ms D] adequately supervised and supported?

[Ms D] reported having little orientation and no performance appraisal. She also reported that she did not have a comfortable working relationship with the nurse manager. The nurse manager took over tasks that were part of the RN's role and did not provide evidence that they had been completed. There was no evidence of formal meetings held that included the RN. I have not been able to find adequate evidence that [Ms D] was adequately supported and supervised. Belhaven Rest Home's peers would view this with moderate disapproval.

7.4 What else, if anything, should Belhaven Rest Home have done in the circumstances?

7.4.1 Referrals for change in care levels

The NP indicated that [Mrs A] should be referred for assessment for an increase in care level to D6 (hospital level care) in a fax dated 26/9/08. The Belhaven staff may have assumed that the NP would make the referral. The referral was finally sent October 13th 2008. The ARRC service provider agreement required that Belhaven Rest Home refer a Subsidised Resident to the Needs Assessment and Service Co-ordination Service for re-assessment if there was a significant change in that subsidised resident's level of need and those needs could no longer be met by the facility or if the DHB requested that the subsidised resident be re-assessed. In my opinion Belhaven Rest Home did not ensure that on the advice of the NP [Mrs A] was referred for reassessment of her care level needs and that this contributed to [Mrs A's] clinical condition at the time of discharge to [the private hospital].

7.5 Further recommendations for improvement

7.5.1 Registered nurse position description

I have reviewed this document as part of the complaint and, in my opinion, it should be reviewed with urgency so that it reflects all the competencies required of a registered nurse. I note that in the restructuring one of the directors had "taken over the care plans". The directors must be clear about the scopes of practice of health professionals and ensure that non-health professionals do not undertake responsibilities within these scopes of practice.

7.5.2 Medication management

I have identified practices that do not meet the standards and relevant guidelines. The prescribing of all medications onto the medication prescribing chart by the GP or NP needs to be actioned. This includes short course and PRN medications. Medication management processes need to be regularly audited for compliance.

7.5.3 Incident reporting

I have identified that not all incidents are recorded on an incident form. This needs to be addressed, as does the investigation and corrective action planning.

7.5.4 Pain Management

I have identified that there were pain management issues. To ensure that care staff respond to residents in pain, additional training should be provided and valid pain assessment tools used. Current evidence-based practice guidelines should be available to the RN.

7.5.5 Integrated clinical records

I have identified that clinical information may have been documented outside of the clinical record, e.g. a communication book. All information should be in the clinical record, and care staff should read the progress notes at the start of every shift. I encourage all daily documentation of care provided, observation made and response to treatment.

8.0 Conclusions

The standard of care provided to [Mrs A] did not meet the required standards as set in section two. In the case of [Ms D] the failure was moderate, in the case of [Ms C] the failure was severe, and in the case of Belhaven Rest Home the failure was moderate. The delay in having [Mrs A] reassessed for care needs level by Belhaven Rest Home was a severe failure.

Noeline Whitehead
Professional Advisor

9.0 Reference list

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Appendix B — Further Expert advice from registered nurse Noeline Whitehead

25th April, 2010

This letter is written in response to your request for a statement in relation to the case 09/01035. The query is whether the "bruises" on [Mrs A's] heels could have occurred in a short time at no fault of the carers.

Description of the injuries on the heels
The areas in question on the heels appeared as blisters filled with serum/blood. The areas underneath the blister surfaces appeared to be black. The margins around the edge of the blisters were red, indicating inflammation was present and that damage had occurred underneath the blisters. The injuries were at least stage 2, but more likely stage 3 pressure ulcers. They were not bruises.

A pressure ulcer is defined as an area of localised damage to the skin and underlying tissue caused by pressure or shear and or a combination of these. Stage 2 pressure ulcers involve partial thickness of the dermis presenting as a shallow open ulcer but may also present as an intact serum or serum/blood filled blister. Where there is the appearance of bruising, this would indicate deep tissue damage (European Pressure Advisory Panel, 2009; Pressure Ulcer Guidelines).

The cause of such injuries
The nature of the injuries to [Mrs A's] heels were related to unrelieved pressure over an extended period of time and/or possible poor techniques when moving and positioning [Mrs A]. As a consequence blood could not circulate to the tissues and waste products could not be removed, cells died and pressure damage occurred.

Evidenced based practice
Pressure ulcers are considered to be an adverse outcome of care. They are preventable and therefore not accepted in the delivery of routine safe care. The elderly, especially when they are unwell, are susceptible to the development of pressure ulcers. There is extensive empirical evidence that if pressure ulcer risk assessments are undertaken by the health professional and the identified areas of risk are addressed with evidenced based practice interventions then pressure ulcers should not develop. Prevention interventions should include: good assessment, repositioning, keeping the heels floating, suitable support surfaces, good skin care, attention to good nutrition and hydration, and staff education.

The management of prevention interventions
In a rest home, the management of these processes are the domain of a registered nurse. He/she has a professional accountability to direct and delegate the second level

nurses and unregulated care givers in the care that is required by an individual resident. It was the role of registered nurse/nurse manager to: (1) identify the increasing deterioration in [Mrs A's] health early in the decline, (2) adequately instruct the care givers, (3) ensure that the care givers were competent to provide the required care, (4) ensure that the care givers provided the care required and (5) reviewed and evaluated the progress of the resident.

The timing of the development of pressure ulcers

When care is inadequate, pressure ulcers may develop in a short period of time. For example research has found that in emergency care and theatre situations where patients are not moved for 4 to 6 hours they are at increased risk of developing a pressure ulcer. The sicker the patient is, the greater the risk, the less time it takes for a pressure ulcer to develop, and the more frequent the care interventions need to be.

Conclusion

In the case of [Mrs A], acceptable practice would have been to reposition her at least every two hours and for her heels to not be in contact with any surface at any time. If this had occurred then the pressure ulcers on the heels would not have developed. Therefore, the time taken for the pressure ulcers to develop is not relevant in this case as the pressure ulcers were preventable.

Yours faithfully

Noeline Whitehead
MN (Hon), PG Dip HSc, RN

Professional Advisor to the Health and Disability Commissioner

Appendix C — Further Expert advice from registered nurse Noeline Whitehead

Medical/Professional Expert Advice 09/01035 Independent Advisor's Report; further comment requested May 2010

The Acting Commissioner has requested comments on the responses to her provisional opinion before she makes her final decision.

In respect of the response By [Ms D]
[Ms D] raises employment issues in her response. The owners and the registered nurses had a responsibility to ensure that employment issues did not impact on the care received by [Mrs A]. I have nothing further to add in relation to this matter. [Ms D] states that she asked the pharmacy for advice in relation to medication management. While I do not dispute that this occurred as stated in [Ms D's] letter she failed to document the advice received. [Ms D] refers to the Lodge Diary and it not being made available as part of the investigation to support the direction she gave to the care staff. I restate that the clinical record should have contained adequate and appropriate information in order to facilitate safe care to [Mrs A]. All the records pertaining to the service delivery to [Mrs A] should have been integrated. This was not the case. It appears that [Ms D] has reflected and acknowledged her "shortcoming" in the care of [Mrs A] and has worked towards improving her practice in a professionally responsible manner.

In respect of the response by [Ms C]
[Ms C] was employed as the nurse manager of Belhaven Rest Home and as such had the responsibility under the Health and Disability Sector Standards to be "accountable and responsible" for the provision of services to [Mrs A]. Further, under the Age Related Residential Care Service Provider Agreement her role included ensuing that [Mrs A] was "adequately cared for in respect of her everyday needs". As the line manager of staff she was responsible to ensure that [Ms D] carried out her duties as set out in her position description.

[Ms C's] response refers to the Lodge Diary and it not being made available as part of the investigation to support the direction she gave to the care staff. I restate that the clinical record should have contained adequate and appropriate information in order to facilitate safe care to [Mrs A]. All the records pertaining to the service delivery to [Mrs A] should have been integrated. If the documentation that [Ms C] states was in the Lodge Diary was available to the professional advisor it could have been taken into consideration. However it was not available.

In regards to medication there was a clearly documented instruction in the clinical record I draw your attention to the last paragraph of clause 4.1.6 regarding pain

management as an example of the issues with medication management. In respect to the antibiotics, it is essential that such medicines are commenced as soon as possible. [Ms C] had a responsibility to ensure that this happened. There was evidence within the progress notes of inadequate bowel care as summarised in 4.1.1 in my report. When reviewing the care of [Mrs A] I was aware that in a letter from Dr H to the Commissioner that Dr H had stated that [Mrs A] was terminally ill. However, there was no evidence anywhere in the clinical record that this was the case nor was there any evidence that this had been discussed with [Mrs A's] family. The care plans did not reflect changes to the care that a terminally ill resident could expect to receive. Dr H's comment helped to reinforce my advice to the Commissioner that [Mrs A] should have been referred for a needs assessment when it was first suggested by the Nurse Practitioner. I refer to my letter dated 25th April, 2010 in reference to the pressure ulcers on [Mrs A's] heels.

In respect to the response by Mrs B

Mrs B's response reinforces that the family of [Mrs A] were not kept fully informed about her condition and her care.

In respect to the response by Belhaven Rest Home

While the owners employed a nurse manager they had a responsibility as directors of the company and holders of the Age Related Residential Care Service Provider Agreement to ensure there were systems in place that provided them with reassurance that [Mrs A] was "adequately cared for in respect of her everyday needs". It is pleasing to see that the owners have made changes to ensure that there is a system of clinical governance in place.

Summary

While some of my findings have been questioned my advice to the commissioner remains unchanged.

Yours faithfully
Noeline Whitehead
MN (Hons), RN.

Appendix D — Relevant standards

Health and Disability Sector Standards (NZS 8143: 2008):

Standard 1.1.8 Consumers receive services of an appropriate standard.

Standard 1.1.10 Consumers and where appropriate their family/whanau of choice are provided with the information they need to make informed choices and give informed consent.

Standard 1.2.9 Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Standard 1.3.3 Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

Standard 1.3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

Standard 1.3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

Standard 1.3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

Standard 1.3.12 Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

Nursing Council of New Zealand's *Competencies for registered nurses* (December 2007):

Competency 1.3 Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others.

Competency 2.1 Provides planned nursing care to achieve identified outcomes.

Competency 2.2 Undertakes a comprehensive and accurate nursing assessment of clients in a variety of settings.

Competency 3.3 Communicates effectively with clients and members of the health care team.

Aged Related Residential Care Agreement (May 2002 and variations)