Radius Lester Heights Hospital

(Radius Residential Care Ltd)

Registered Nurse, Ms D

A Report by the

Deputy Health and Disability Commissioner

(Case 09HDC01974)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. This report is about the failure by a hospital-level rest home to provide an appropriate standard of care to a new resident.

2. Mrs A, aged 84, had chronic renal failure, a long history of urinary tract infections, and only one kidney. She was transferred to Radius Lester Heights Hospital (Lester Heights) from her local rest home, as her needs had increased to the point where hospital-level care was required.

3. Over a four-day period Mrs A became dehydrated and her health significantly deteriorated. On Thursday night Mrs A was admitted to the public hospital where tests confirmed that she had a urinary tract infection and acute on chronic renal failure[1] (secondary to dehydration). Mrs A was treated with intravenous (IV) antibiotics and fluids and initially improved but declined after the IV fluids were stopped. Sadly, Mrs A died a few days later.

Decision summary

4. Mrs A did not receive an appropriate standard of care while she was a resident at Lester Heights.

5. Clinical Nurse Manager, Ms D, did not admit Mrs A to Lester Heights in accordance with policy. She failed to ensure that Mrs A's initial assessment and care plan were adequately completed on admission, and did not inform other staff that Mrs A was on a fluid balance chart. Ms D also failed to adequately oversee the clinical care provided to Mrs A by the nurses and caregivers. Accordingly, Ms D breached Rights 4(1)[2] and 4(2)[3] of the Code of Health and Disability Services Consumers' Rights (the Code).

6. Radius Residential Care Limited[4] (Radius), owner of Lester Heights, was ultimately responsible for the poor standard of care that Mrs A received. Radius breached Right 4(1) of the Code for failing to ensure that Lester Heights' staff provided quality care to Mrs A and that staff complied with the relevant policies and procedures to provide the care needed.

7. Registered Nurse Ms E did not respond appropriately to Mrs A's daughter's concerns or document her communication with the family in Mrs A's records.

[1] This is when an acute kidney injury presents in a patient with chronic kidney disease.
[2] Right 4(1): Every consumer has the right to have services provided with reasonable care and skill.
[3] Right 4(2): Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
[4] Radius Residential Care Limited changed ownership in 2010.

Complaint and investigation

8. On 24 October 2009, the Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Radius Lester Heights Hospital (Lester Heights) to her late mother, Mrs A.

9. An investigation was commenced on 23 February 2010. The following issues were identified for investigation:

- *The adequacy of the services provided by Radius Residential Care Ltd to ensure Mrs A received an appropriate standard of care over a period of four days in mid 2009.*
- *The appropriateness of the care provided by Registered Nurse Ms D to Mrs A over a period of four days in mid 2009.*

10. On 26 November 2010, the investigation was extended to include the following issue:

- *The appropriateness of the care provided to Mrs A by Registered Nurse Ms E between over a period of four days in mid 2009.*

11. Information was received from the following parties who were directly involved in the investigation:

Ms B	Complainant
Radius Residential Care Ltd	Provider
Ms C	Provider/Facility Manager
Ms D	Provider/registered nurse
Ms E	Provider/registered nurse
Ms F	Provider/registered nurse
Ms G	Provider/registered nurse
Ms H	Provider/registered nurse
Ms I	Provider/enrolled nurse
Dr J	Provider/physician

Also mentioned in this report:

Mr K	Caregiver, previous rest home
Ms L	Regional operations manager
Ms M	Chief operating officer
Ms N	Registered nurse
Ms O	Facility Manager at another Radius facility

12. Independent expert advice was obtained from a registered nurse, Glenda Brady (who has expertise in aged care), and is attached as an appendix.

13. This report is the opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

Information gathered during investigation

Mrs A

14. On a Monday in mid 2009, Mrs A transferred to Lester Heights from a rest home where she had resided for three years, as her needs had increased to the point that hospital-level care was required. Mrs A was a resident at Lester Heights for a total of four days.

Radius Lester Heights Hospital

15. Lester Heights is a 35-bed licensed facility providing hospital, palliative, and respite care to both elderly people and young disabled people.[5] It is one of 21 residential care facilities throughout New Zealand operated by Radius.[6] Radius describes itself on its website as "a specialist health care provider for older New Zealanders" providing both hospital and rest home services to over 800 clients around New Zealand.[7]

Clinical Nurse Manager

16. Between June 2008 and September 2009, Radius employed Ms D to work at Lester Heights as Clinical Nurse Manager (CNM) "for a minimum of 24 hours per week".[8] Radius advised HDC that its understanding of this arrangement was that Ms D would work three days per week as CNM and two days per week as a registered nurse (RN). Ms D told HDC that she was employed to work as CNM five days per week and she was not employed to work as an RN "on the floor".

17. Ms D was responsible for roster management. She was CNM for the four days that Mrs A was resident at Lester Heights.

18. The CNM job description requires the CNM, amongst other things, to:

- take ownership of the Radius Residential Care philosophy and motivate staff to provide an excellent quality of service;
- ensure excellent standards of clinical practice are implemented;
- ensure effective communication and teamwork with other staff, residents, and families/whānau;
- effectively lead staff so that unwanted behaviours are identified and eliminated;
- ensure all care staff receive adequate orientation and ongoing training in order to maintain a safe environment for clients; and
- support and coach staff to take full responsibility for the requirements of their role.

[5] Facilities offering hospital-level care are required to have a registered nurse on duty 24 hours a day, seven days a week.
[6] Reference in this report to Lester Heights includes Radius Residential Care Ltd.
[7] The hospital services offered by Radius include long-term care, respite, palliative care, care for young disabled persons, care for dementia sufferers, hospice care, and complex medical care. The rest home services offered by Radius include long-term residential, respite, and palliative care, care for young disabled persons, care for dementia sufferers, and day care.
[8] This wording is taken from Ms D's employment agreement with Radius.

19. In her role as CNM, Ms D had overall responsibility for clinical operations and was responsible for providing clinical oversight, support, coaching and leadership to the RNs, Enrolled Nurses (ENs) and health care assistants (HCAs), co-ordinating client care, and ensuring clinical care complied with professional standards.

20. Radius advised HDC that while there was some overlap between the two roles held by Ms D, such as co-ordinating resident care, she was not required to work "on the floor" as an RN when she was rostered on as CNM. Similarly, when she was rostered on as an RN, she was not required to complete tasks relating to her role as CNM.

Facility Manager

21. Radius employed Ms C to work at Lester Heights as its Facility Manager from January 2008 until she resigned in January 2010. The Facility Manager job description stated that the main purpose of the role was "[to] manage staff and resources to ensure the delivery of safe and effective, quality life and health care services are provided to all residents within the facility". As Facility Manager, Ms C was responsible for the day-to-day running of the facility, which involved recruiting staff, promoting Radius and maintaining facility occupancy, ensuring expenditure was within budget, and managing a commercial laundry that serviced four Radius facilities.

22. Ms C was not an RN and therefore not directly responsible for the clinical care provided to residents; this was the CNM's role. However, the Facility Manager job description states that a key activity of the Facility Manager was to ensure "excellent standards of clinical practice are implemented, and gerontological best practice is delivered at all times".

23. Ms C advised HDC that to fulfil this part of her role, she:

1. read the residents' notes to keep herself informed and asked Ms D to inform her about any clinical issues with residents;
2. asked the RN on duty and Ms D, on arrival and on leaving the facility each day, if they had any concerns;
3. met with Ms D daily to discuss clinical issues if required;
4. met with Ms D weekly to ensure there was clear communication and that issues raised were dealt with proactively;
5. regularly sat in on afternoon handovers with all staff; and
6. held monthly meetings with the registered nurses. Part of these meetings would consist of training and the other part would consist of working through issues and reviewing clients' care.

24. In addition to the above, Ms C advised HDC that she asked all staff to complete the latest "self directed learning and orientation package" to ensure they were up to date with Radius's policies and procedures, and organised clinical care support and training for the RNs to ensure they were aware of their responsibilities. She also ensured the RNs were aware that Ms L (Regional Operations Manager), Ms M (Chief Operating Officer), and the CNM at another Radius facility were available to them for support if needed.

25. At the time of the events complained about, Ms C was also the interim Facility Manager at another Radius facility, located 20 minutes away from Lester Heights. Ms C carried two mobile phones with her at all times, and Ms D had access to Ms C's online calendar, which detailed where she planned to be and what she was doing. Ms C advised HDC that when she was not on-site at Lester Heights, Ms D was in charge of the facility.

Other staff

26. Radius also employed five RNs and one EN. The RNs were responsible for assessing, planning, and co-ordinating residents' care at Lester Heights.

27. Radius's RN job description requires the RNs to, among other things:

- provide individualised, evidence-based nursing care to residents;
- demonstrate skills in clinical health and social assessment using advanced nursing knowledge from a broad base of health science;
- anticipate deterioration and subtle changes in residents' health status before explicit signs are obvious, and act accordingly;
- interpret data and planning care;
- communicate findings to the clinical team;
- oversee and ensure ongoing assessment and documentation of residents' needs;
- interpret data and pass on appropriately as evidenced by documentation in the multidisciplinary notes; and
- practise nursing in a professional manner demonstrating accountability for own scope of practice and in accordance with Nursing Council Code of Conduct.

28. The "main purpose of the job" as described in the RN job description is to provide "professional nursing care to clients to optimise their health, level of function and wellbeing and provide support for family/whanau". The RNs were also responsible for supervising the HCAs.

29. The HCAs were responsible for providing daily cares to the residents, alerting the RNs to any concerns they had about residents, and carrying out the nurses' instructions.

Transfer to Lester Heights

30. Mrs A had only one kidney, chronic renal failure, and a long history of urinary tract infections (UTIs).[9] She had been assessed by the Needs Assessment and Service Co-ordination Service (NASC) as requiring hospital-level care since February 2009; however, she remained at her first rest home owing to her "changing abilities" and her family's wish for her to remain as long as possible, as she was settled there and fond of the staff.

[9] A bacterial infection affecting any part of the urinary tract.

31. At 1.30pm on Monday, Mrs A arrived at Lester Heights with Mr K, a caregiver from her previous rest home. The information contained in the "Discharge/transfer form" from [previous rest home] to Lester Heights included the following:

> "Diagnosis: History of depression (not currently receiving treatment). Renal failure with severe fatigue and sensitivity to cold (has only one kidney). History of UTI — now has permanent UTI … K[l]ebsiella pneumoniae.[10]
>
> …
>
> Feeding: Can feed herself SLOWLY with encouragement however is in need of feeding regularly to ensure adequate intake. Is able to drink fluids placed in front of her but needs regular checking as falls asleep regularly."

32. Ms C recalls that, on Mrs A's arrival at Lester Heights, she introduced herself to Mrs A and ensured that she was settled. She informed Mrs A that the CNM would be "down shortly" and that she (Mrs A) would be admitted that afternoon. Ms C then left Mrs A and went to Ms D's office and informed Ms D that she was leaving to go to the other Radius facility that she was managing.[11] Ms C then left Lester Heights and was not on-site at Lester Heights for the remainder of Mrs A's time there.

33. Ms D was rostered on as CNM for the morning and afternoon shifts on the day of Mrs A's arrival. An EN at Lester Heights, Ms I, was rostered on the morning shift but no RN was rostered on until 2.45pm.

34. EN Ms I advised HDC that she was instructed to document Mrs A's arrival and any relevant information. Mr K gave EN Ms I some information about Mrs A's cares and she documented this in Mrs A's progress notes. EN Ms I also received some paperwork (including clinical information) from Mr K and placed this on Mrs A's file. EN Ms I recalled Mr K telling her that Mrs A was in chronic renal failure "and with only one kidney her outcome was not good". EN Ms I also recalled Mr K's advice that Mrs A "had become very ill in the last week and that [the previous rest home] could no longer care for her".

35. EN Ms I documented the following information in Mrs A's progress notes:

> "[Mrs A] arrive[d] at [1.30pm] with daughter and [health care assistant] from [the previous rest home]. [Mrs A] has only one kidney, renal failure, and suffers severe fatigue. Has history of UTIs and now permanent UTI, is allergic to Triprim.[12] In the last 6 weeks [Mrs A] had deteriorated in condition. She has had bilateral knee replacements and requires 2 nurses to stand her at rail when doing [Mrs A's] cares. Her speech is normal and [Mrs A] wears glasses, she also has good hearing. Her meals are mouli and she drinks black tea. [Mrs A] is incontinent and wears incontinence pads day and night. She is in room [number]."

[10] A type of bacteria.
[11] Ms D told HDC that Ms C "did not inform [her] of anything".
[12] An antibiotic used to treat acute UTIs and prevent them from recurring.

36. Ms D advised HDC that she understood that the previous rest home was relieved to move Mrs A on, as staff did not expect her to live to the end of the week. This is strongly refuted by Mrs A's daughter, Ms B, who told HDC that she found this remark to be "callous and offensive". Ms B told HDC that the previous rest home decided her mother should be transferred to hospital-level care because her condition was slowly deteriorating, she needed two staff to do her cares, the rest home no longer had the resources to spare, and there was no way of knowing how long this situation might continue. Ms B told HDC that if the rest home thought Mrs A "would not last the week", staff would have kept her there, as they had done this in 2007 when Mrs A had a serious infection and they thought she might die. Ms B also noted that there is nothing in the handover report from the previous rest home to support Ms D's statement.

37. Ms C advised HDC that prior to Mrs A's admission she had met Ms B, and spoken to the manager at the previous rest home. Ms C recalls being advised that Mrs A's renal condition had been managed well for many years and there was no indication that Mrs A was being transferred to Lester Heights for palliative care.

Initial Assessment/Care plan

38. Radius's policy specifies that an RN is responsible for admitting a client to a Radius facility.[13] The RN responsible for admitting the client is obliged to "complete the Initial Assessment/Care plan during the shift on which the client is admitted".[14] Other than completing the Initial Assessment/Care plan, Radius's policy does not provide any information about what the formal admission process involves. The Initial Assessment/Care plan is intended as a short-term assessment of the client's needs until the full multidisciplinary assessment and care plan is completed.[15]

39. Although Ms D was rostered on as CNM when Mrs A was admitted to Lester Heights, she was the only qualified RN working at the time. Radius advised HDC that, accordingly, Ms D was required to provide RN support and oversight to EN Ms I, irrespective of the fact that she was rostered on as CNM.

40. An Initial Assessment/Care plan for Mrs A was commenced, but not completed. It recorded information about Mrs A's mobility, communication, drink preferences, elimination, cleansing and dressing, controlling body temperature, skin, independence and interests. There were spaces to document information about Mrs A's falls risk, orientation, usual sleeping hours, pain relief, dietary requirements, and views on death and dying, but these were not completed. There was also space for an RN to sign and date the form but this was not done.

[13] Assessment, Care Planning and Review Policy and Procedure.
[14] The timeframe in the policy for an initial assessment to be completed differs from the timeframe contained in Radius's job description for an RN, which requires the RN to develop an initial care plan "within 24 hours of admission".
[15] Radius's Assessment, Care Planning and Review policy requires the full multidisciplinary client assessment to be completed within three weeks of admission.

41. RN Ms F took Mrs A's baseline observations[16] the following day and recorded these in Mrs A's Initial Assessment/Care plan.

42. Other than the baseline observations, it is not clear who conducted the initial assessment and completed Mrs A's Initial Assessment/Care plan form. Ms D denies that she did, advising that it was not her responsibility to write the care plan for Mrs A, and added that she has never met Mrs A's daughter (who accompanied Mrs A on admission). Ms D advised HDC that EN Ms I admitted Mrs A and conducted the initial assessment. Ms D described EN Ms I as "very competent" and advised HDC that on admission "baseline observations were done, fluid balance chart commenced, as was close monitoring for increased confusion, decreased urinary output, excessive drowsiness, rapid pulse, marked change in blood pressure indeed anything out of the ordinary. Fluids were offered every hour."

43. However, EN Ms I advised Radius that she did not complete the Initial Assessment/Care plan form. She advised HDC that Mrs A was transferred to her room by an RN for an initial assessment and to have her observations taken. EN Ms I is not an RN, and Radius's policy requires an RN to be responsible for admitting residents.

44. Ms B's recollection is that her mother was not assessed on admission. Ms B advised HDC that on arrival, her mother was taken to a communal sitting room while Ms B spent some time organising her mother's room. Ms B advised HDC that she went back and forth from her mother's room to the communal sitting room and does not recall seeing her mother being assessed or being asked about fluid intake. She does recall being told by the person who escorted them to the sitting room that someone else would be along later "to do all the formal stuff". Ms B recalls thinking at the time "that it all seemed very casual for a 'hospital'".

Monday — Handover

45. Radius's "Handover of Client Care Between Duties Policy and Procedure" states that "[a]ll care staff have a responsibility to pass on a verbal/written handover report to the person/s in charge at the end of each shift", and that "[s]taff commencing duty must receive both a verbal handover and are responsible for reading the multidisciplinary progress notes and care plans".

46. The same policy requires that "[a]ll new treatments and incidents should be reported at the handover". The handover sheet is updated each morning and on each subsequent shift if there are any new changes or concerns. The handover sheet is used in addition to the verbal handover report that takes place at the changeover of every shift.

47. Immediately following EN Ms I's entry in Mrs A's progress notes on Monday, an HCA recorded "Poor oral intake. Sponge washed … skin check done."

[16] Mrs A's blood pressure, pulse, temperature and respiratory rate were recorded. Mrs A's weight was not recorded.

48. RN Ms N was on duty from 2.45pm until 12.30am on the day of Mrs A's arrival at Lester Heights. There is no documentation from RN Ms N in Mrs A's progress notes.

49. Radius's "Clinical Records Policy and Procedure" requires all staff to record each assessment, event, visit, treatment, intervention, procedure, and consultation in the resident's progress notes as soon as practicable after it has occurred.

50. The same policy also states that "[h]ealth professionals should document as frequently as indicated by the clinical condition of the patient/client. They should document each patient/client contact in the health record, or one entry per shift, whichever is more appropriate." All discussions and exchange of information with family are to be recorded on the Communication with Family Record.

51. RN Ms G worked from 10.45pm on Monday until 7.15am on Tuesday. RN Ms G advised HDC that she received a detailed handover about Mrs A at the start of her shift, and this included advice about Mrs A's history of UTIs, but that no concerns about dehydration were mentioned. RN Ms G advised HDC that Mrs A was asleep during all of her routine checks throughout her shift, and therefore she did not officially meet Mrs A. RN Ms G did not document anything in Mrs A's progress notes.

Tuesday — Fluid balance chart

52. At some point during the morning shift on Tuesday, a fluid balance chart was commenced for Mrs A. There is no documentation recording the commencement of the fluid balance chart for Mrs A, and no evidence to indicate that Dr J or the other RNs were notified about the fluid balance chart.

53. There is no indication on the chart or in Mrs A's progress notes as to who commenced the chart. However, Radius advised HDC that the fluid balance chart was commenced by Ms D. EN Ms I advised HDC that "[Ms D] put [Mrs A] on a fluid balance chart". Ms D advised HDC that she "instructed staff on the floor to start a [fluid balance chart]".

54. HCAs recorded on the fluid balance chart that on Tuesday, Mrs A was offered 150mls of tea or juice at 10am, 11am, 12pm and at "afternoon tea". It is noted that Mrs A refused all these drinks except for a "small sip" of juice at 11am and "some" tea at 12pm. In the urine output column under "volume given", "50mls" has been recorded next to "Afternoon tea black tea 150mls".

55. Radius's "Nutrition and Hydration Policy and Procedure" requires that a full assessment of nutrition and hydration is completed on admission. Any client who demonstrates clinical signs of dehydration or is at risk of dehydration is required to be commenced on a fluid balance chart, the medical officer is to be notified, and a hydration assessment is to be completed each duty by clinical staff.[17]

[17] Radius's Nutrition and Hydration Policy and Procedure contains a "Hydration Assessment Checklist" which lists the following factors to be considered to determine the risk for diminished hydration: fever,

56. The policy does not specify who is responsible for conducting the hydration assessment on admission. However, an RN is responsible for conducting an initial assessment of a new resident on admission, and Radius advised HDC that the decision to initiate a fluid balance chart would occur as a result of a nursing or medical assessment undertaken by the RN or medical officer.

57. A fluid balance chart has space to record the volume of a resident's fluid intake and urine output over a 24-hour period. There is no information contained in the policy on how to measure the urine output of residents who are incontinent. Radius advised HDC that in these circumstances the pad is assessed for how wet it is (ie, damp, wet, very wet, saturated) or by weighing the pad, as each pad has a different volume capacity. However, Radius acknowledged that this method "may be hampered if the pad is also soiled". Radius advised that consideration may also be given to catheterisation following discussion with the GP and family, but only if the GP deemed it to be imperative, given the invasive nature of the procedure.

58. Radius also has a "Nutrition and Hydration Care Guide" which specifies the first, second, and third line of treatment for dehydration. The first line of treatment involves recording fluid input/output on a chart for three days, ensuring the patient drinks a minimum of 1.6 litres per day, offering the patient fluids of choice every two hours, encouraging oral intake each medication round, reviewing the patient's medication, and reassessing the patient after 24 hours.

59. It is not clear who, from Radius's policies, is responsible for recording the volume of fluid intake and output on the fluid balance chart. However, fluid balance charts are included as part of the orientation of all HCAs, ENs and RNs. The HCAs give the residents their drinks and tend to their personal cares.

60. Fluid balance charts are not kept in the body of the resident's notes, but on a clipboard in the nurses' station.

61. Radius advised HDC that it "expects both the Clinical Manager and Registered Nurses to oversee [the fluid balance chart] process to ensure accurate recording, completion and assessment of the fluid balance chart".[18] Although Radius was unable to locate any information regarding specific training provided to the ENs and RNs in relation to fluid balance charts, it advised that the RNs involved in Mrs A's care had confirmed that hydration and fluid balance charts were covered in their comprehensive training. Radius advised that "[b]y virtue of experience, all of these nurses would have had previous knowledge and experience on the use of fluid balance charts and clinical management of hydration needs of residents".

thirst, aged greater than 85 years, physical immobility, fluid intake less than 1.5 litres, cognitive impairment, medications, medical history, etc.

[18] The RN job description requires the RNs to provide supervision and coaching of caregivers involved in delivery of care to achieve outcomes identified in the care plan and reduce variation in care.

Tuesday — Handover

62. Ms B visited her mother on Tuesday morning. She noted that her mother looked well cared for and commented to the HCA that it was nice to see her mother in matching clothes with her hair done. Ms B noted that her mother "seemed very sleepy and unresponsive, but again this was not unusual".

63. That morning an HCA recorded in Mrs A's progress notes that Mrs A had "a sore tummy but eats well". Later that day a different HCA recorded: "Poor oral intake, only had a few sips of tea, refusing all meals, saying she feels sick and has a sore tummy, appears to be dry retching at times … concerned about oral intake, lots of encouragement needed."

64. RN Ms E was on duty from 6.45am to 3.15pm on Tuesday. She advised HDC that she received a verbal handover about Mrs A at the commencement of her shift and there "was no mention of fluid intake or output being recorded on a fluid balance chart or any ongoing concerns with fluid intake". RN Ms E recalls Mrs A "drinking good amounts of water when taking her medications", but did not record this on the fluid balance chart as she was not aware that one had been commenced.

65. RN Ms E did not record anything in Mrs A's progress notes but she documented the following on the daily RN handover sheet in relation to Mrs A: "2x [small] vomits. Walk frame x2. 1 mouli/norm[al] fluids …"

66. RN Ms F was on duty from 2.45pm until 11.15pm on Tuesday. RN Ms F advised HDC that while she was advised about Mrs A's general medical conditions and personal care requirements, she was not informed of any concerns regarding Mrs A's health. As RN Ms F knew the doctor was attending that afternoon, she asked Ms D if there were any concerns with the patients and was advised there were none.

67. RN Ms F advised HDC that she checked the RN daily handover sheet and there were no concerns written with regard to Mrs A. She also read Mrs A's notes from the previous rest home, taking note of Mrs A's current health problems, medications, variance in her level of alertness, and variance in her food and fluid intake. RN Ms F then visited Mrs A and took her baseline observations (all within normal ranges) for the upcoming medical assessment, and recorded these on Mrs A's Initial Assessment/Care plan. RN Ms F recalls that Mrs A was alert and responding to questions but complained of a sore abdomen.

68. RN Ms F advised HDC that she was never informed at handover that a fluid balance chart had been commenced for Mrs A, and that the HCA would not have known to document what Mrs A had eaten and drunk. RN Ms F added that the HCA responsible for Mrs A never advised her verbally about her concerns regarding Mrs A's food and fluid intake, but RN Ms F acknowledged that the HCA had documented her concerns in Mrs A's progress notes.

Initial medical assessment

69. At 5.10pm on Tuesday, Dr J saw Mrs A for her initial medical assessment.[19] This took place during dinner time and RN Ms F recalls that an HCA verbally advised her that Mrs A had not eaten much but had drunk a glass of water.

70. RN Ms F was present during Dr J's assessment and advised HDC that she informed Dr J about Mrs A's sore abdomen, constant UTIs, and her rapid decline in condition in the past six weeks. RN Ms F recalls that Mrs A was alert and responding to Dr J's questions, but was very tired.

71. Dr J took a detailed history from Mrs A, examined her fully, and reviewed her discharge summary from the previous rest home.

72. On the form headed "Initial Medical Assessment", Dr J recorded that Mrs A had deteriorated in the past six weeks, her energy levels and mobility had decreased, and her care requirements were increasing.

73. Under "Past Medical and Surgical History" Dr J documented Mrs A's medical conditions including her history of UTIs (and that it was now a longstanding infection), renal failure/impairment, one kidney, hypertension, fatigue, and cold sensitivity. He also noted Mrs A's allergies/intolerances to a number of antibiotics.

74. Dr J also recorded Mrs A's medications on admission. These included regular diuretics (frusemide, 80mg daily and spironolactone, 25mg daily). On examination of Mrs A, mild bilateral ankle oedema was noted. Her JVP[20] was not identified, pulse was 88 beats per minute (bpm), and blood pressure was 128mmHg/88mmHg.[21]

75. Mrs A complained of tiredness and mild lower abdominal pain with intermittent nausea, but no vomiting. Dr J examined Mrs A's abdomen and suspected her symptoms were caused by an acute on chronic UTI. He therefore requested a sample of Mrs A's urine to be sent to the laboratory for testing. He did not do a urine dipstick[22] as he believed this would be "ambiguous/meaningless in the face of known chronic urinary tract infection".

76. Some shortness of breath and basal lung crepitations[23] were also noted. Dr J advised HDC that upon questioning Mrs A about her shortness of breath, she stated that this was "no worse than usual for her, and that this breathlessness, together with some lack of energy and fatigue, had been present for at least 6 weeks or more".

77. Dr J felt Mrs A's condition "was similar to what had been described before". He therefore wrote up her admission notes, prescribed some anti-emetics for her nausea,

[19] It is Radius's policy that clients are assessed by a medical officer within two days of admission.
[20] Jugular venous pressure.
[21] 110–140mmHg/70–80mmHg is considered normal.
[22] A plastic strip with several different coloured squares on it. When the strip is dipped into a urine sample the squares change colour, providing important information to assist with diagnosis.
[23] Dry crackling sounds in the base of the lung.

requested routine blood tests, and asked the nurses to "[o]bserve for [increasing shortness of breath], pain".

78. RN Ms F recorded that Mrs A had been seen by Dr J for her initial medical assessment, and that she was to have a blood test and urine sample sent for analysis. This is the only documentation by an RN in Mrs A's progress notes during the four days Mrs A resided at Lester Heights.

79. RN Ms F advised HDC that after Dr J's medical assessment, she gave Mrs A her medication, which she took with a full cup of water, and she made Mrs A a cup of tea. RN Ms F did not document this contact.

80. An HCA recorded in Mrs A's notes: "Poor oral intake ... seemed to be quite lethargic this shift. Settled to bed at [7pm]."

Tuesday — overnight shift

81. RN Ms H was the RN on duty overnight on Tuesday. Her shift commenced at 10.45pm on Tuesday and finished at 7.15am on Wednesday. RN Ms H advised HDC that she checked on Mrs A every two hours on her routine round checks. She did not have any concerns about Mrs A and recalls that she slept well. RN Ms H did not document any information in Mrs A's progress notes.

Wednesday

82. Ms B visited her mother at lunchtime on Wednesday. Ms B found her mother in the dining room, sleepy and shaking. She was alarmed as she had not seen her mother shaking before. Ms B noted that a cup of tea was in front of her mother but she was not drinking it. An HCA advised Ms B that she was concerned that Mrs A had eaten only a few bites at breakfast and lunch, and asked Ms B what her mother would like to eat. Ms B suggested they mouli some silverbeet and eggs. The HCA did so but when Ms B attempted to feed it to her mother she refused to eat it, and also refused to drink her cup of tea. Ms B advised HDC that this was "most unlike" her mother.

83. The HCA from the morning shift recorded in the progress notes that Mrs A had "very poor oral intake" and that she had "informed RN and [Mrs A's] daughter about her eating".

Wednesday — Handover

84. RN Ms E was the RN on duty from 6.45am until 3.15pm on Wednesday.[24] She advised HDC that she received a verbal handover and no concerns were raised about Mrs A's fluid intake. There was no mention about Mrs A being on a fluid balance chart. RN Ms E recalls seeing Mrs A with a cup of tea with milk and that she changed this to a cup of black tea. There is no documentation in Mrs A's progress notes from RN Ms E on this shift.

[24] The roster indicates that both Ms D and Ms E were rostered on as RN on Wednesday morning. Radius advised HDC that this was a typographical error on the roster, as Ms E recalls working the morning shifts from Wednesday to Friday.

85. RN Ms H commenced her shift at 2.45pm and worked until 12.30am. RN Ms H advised HDC that she does not recall any concerns about Mrs A being noted at handover and she did not have any concerns about Mrs A during her shift. She did note, however, that Mrs A's fluid intake was being recorded on a fluid balance chart, which was held in the nurses' station. There is no documentation in Mrs A's progress notes from this shift, and nothing is recorded on Mrs A's fluid balance chart after morning tea at 10am.

86. According to Mrs A's fluid balance chart, at 8am on Wednesday, 150mls of tea was offered to Mrs A and 20mls of fluid output is recorded. It does not record how much tea Mrs A accepted. At 10am Mrs A was again offered 150mls tea, and refused it. There is no indication as to who made these entries on the fluid balance chart.

87. An HCA documented in Mrs A's progress notes: "Good oral intake — soup, 4 mouthfuls main, dessert and cuppa tea and [biscuits] for supper. Settled well."

Wednesday — overnight shift

88. A bureau nurse was on duty overnight on Wednesday. There is no documentation about Mrs A overnight.

Thursday

89. On Thursday the HCA from the morning shift recorded in Mrs A's notes: "Poor oral intake, very sleepy, but talking quite a bit during her cares."

90. RN Ms E was on duty from 6.15am until 4.45pm on Thursday. RN Ms E advised HDC that she relied on the verbal handover from the nursing staff (no concerns were raised) and did not read the HCA's concerns about Mrs A's poor oral intake from the previous day, which were documented in the progress notes.

Thursday — Ms B's visit

91. Ms B visited her mother mid-afternoon on Thursday during "happy hour" when drinks were being served to the residents. Ms B asked her mother if she would like a drink and recalls that her mother "nodded vigorously". An HCA made Mrs A a weak shandy. Ms B noted that her mother was very weak and trembling and was unable to hold the glass or raise it to her mouth. Ms B assisted her mother and noticed that her mother "gulped it down". When Ms B asked her mother if she felt unwell, her mother replied, "Thirsty." Ms B advised HDC that her mother had a second drink and "gulped" this down as well. Ms B found the speed at which her mother was drinking to be unusual, and also noted that her mother's hand looked very thin and her engagement ring was falling off her finger.

92. Ms B was "seriously alarmed" at her mother's state and went to the nurses' station to advise the RN about her concerns. She advised RN Ms E that her mother was very thirsty and shaking; that this was new and unusual; and that she believed her mother should be seen by a doctor.

93. RN Ms E advised Ms B that her mother had had a blood test that morning and the doctor had seen the results. Ms B asked RN Ms E for a copy of the blood test results so

she could fax them to her brother, who is a GP.[25] Ms B did not think RN Ms E seemed "very keen on this idea" and appeared distracted with people coming and going from the nurses' station. Ms B advised HDC that RN Ms E refused to provide her with a copy of her mother's blood test results or fax them to her brother, saying that she would have to get consent from the GP who ordered them.

94. Ms B then asked RN Ms E for Dr J's telephone number so she could call him herself. Ms B recalls that RN Ms E replied that Dr J was based at the hospital, and was unable to give out his personal telephone number, citing privacy reasons. Ms B found this to be "completely unsatisfactory", and she returned to work and "spent a fruitless and worrying couple of hours trying to find this mystery GP's number in the phone book".

95. RN Ms E advised HDC that she offered to take Ms B's contact details and pass these on to Dr J, as she "was not at liberty to give out personal phone numbers", but that Ms B did not comment on her offer. When Ms B requested a copy of her mother's blood test results, RN Ms E advised HDC that she was unsure of the process around this, and sought advice from Ms D. RN Ms E advised HDC that she explained to Ms D that Ms B wanted to send a copy of the blood test results to her brother, who is a GP, and that Ms B was concerned about her mother's condition.

96. RN Ms E advised HDC that Ms D gave her permission to photocopy Mrs A's blood test results but, to her knowledge, Ms D did not speak with Ms B. RN Ms E recalls that while she photocopied the results, EN Ms I (who was on duty from 2.45pm until midnight) took Mrs A's blood pressure (145mmHg/75mmHg), pulse (96–100 bpm), and respiration rate (20–22 breaths per minute). RN Ms E cannot recall if she gave Ms B a copy of her mother's blood test results after she had photocopied them.

97. Ms D provided a different account from that of RN Ms E. Ms D advised HDC that RN Ms E only came to see her later and informed her that Mrs A's daughter had come in and requested Dr J's contact number and a copy of her mother's blood test results to send to her brother, a GP. Ms D recalls that RN Ms E told her she had refused to provide these for privacy reasons. Ms D recalls that she told RN Ms E she had done the right thing. Ms D advised HDC that they would get requests from families of residents all the time "for these sorts of things, thinking that they know someone who can do it better", but that it was best for families to speak to Dr J. Ms D advised HDC that she was never informed about any major concerns about Mrs A until she was transferred to the public hospital.

98. Neither RN Ms E nor Ms D recorded anything on the Communication with Family Record form. Radius advised HDC that it is disappointing that this did not occur.

99. Dr J received a telephone call on Thursday afternoon from RN Ms E, advising that Mrs A's blood test results taken that day showed a high white cell count (WCC). Dr J advised HDC that "[b]esides the high WCC, [RN Ms E] was not yet too concerned and

[25] Ms B did not speak to her mother about requesting a copy of her blood test results, as she advised that her mother "was in no fit state to have such a conversation".

reported that [Mrs A's] observations were satisfactory except for a respiratory rate of 20. Other blood results were either not available or reported yet."

100. After checking that Mrs A's previous WCC (done recently by Mrs A's doctor at the previous rest home) was normal, Dr J prescribed Mrs A a broad-spectrum antibiotic by fax.

101. EN Ms I documented the following in Mrs A's notes on Thursday:

> "[Dr J] rang concerning blood results — [RN Ms E] faxed blood results. [2.30pm] obs[ervations] done …"

Thursday — Evening handover

102. RN Ms E advised HDC that at the end of her shift she gave a verbal handover to EN Ms I and the HCAs. She does not recall what information she gave them about communicating with Dr J or following up Ms B's concerns.

103. There is no documentation in Mrs A's progress notes from RN Ms E on this shift. RN Ms E advised HDC:

> "I have not recorded any observations in the multi-disciplinary notes as I did not find and was not informed of any concerns of [Mrs A's] state of health that differed from information obtained on admission and my observations."

Transfer to hospital

104. At 6.12pm on Thursday, Dr J received a telephone call from EN Ms I, advising that Mrs A was looking pale and unwell and her condition had deteriorated. Dr J advised EN Ms I to give Mrs A a dose of antibiotics and take her observations again in one hour's time. If there was no improvement then hospitalisation would be imminent.

105. EN Ms I documented in Mrs A's notes:

> "[Mrs A] drinking minimal — refused dinner — very shaky — [complaining of] feeling hot. Temp 35.6°C — looking very pale. Rang [Dr J] [6.15pm] and will do hourly obs on [Mrs A] — 5mls Cefaclor given [5.30pm] as per charted — [Mrs A's] daughter [Ms B] contacted and message left on answer phone.
>
> [9.40pm] [Mrs A] very uncomfortable. Extremities cold to touch — BP 110/50, pulse 102, resp[iratory rate] 18, still semi-responsive."

106. EN Ms I called an Accident and Emergency centre and informed them of Mrs A's condition. At 9.55pm she called for an ambulance and informed Ms B.

107. Mrs A was taken by ambulance to hospital. Tests confirmed that she had a UTI and acute on chronic renal failure (secondary to dehydration). Mrs A initially improved but once IV fluids were stopped she was unable to maintain an adequate fluid intake and her condition declined. A few days later, it was decided (with the family's agreement) to treat Mrs A palliatively, and she died that night.

108. Dr J advised HDC that unfortunately, throughout Mrs A's admission at Lester Heights, he was never informed of her poor oral intake or the fact that her daughter was very upset and concerned regarding her mother's well-being and change in condition. Dr J further commented, "It is particularly disappointing that [Ms B] was not given my number, nor was I, at the very least, contacted by the Lester Hospital nurse(s) on duty regarding her request. A conversation at this time may have led to more timely intervention and earlier acute care as appropriate."

109. Dr J advised HDC that following this incident he requested that any hospital-level patient who does not get admitted directly from a public hospital be assessed by his or her usual general practitioner in the week preceding their admission to Lester Heights. Dr J hopes that this will ensure that any marked change or deterioration from usual will be documented in the resident's recent medical progress notes.

Ms B's complaint to Radius

110. While Mrs A was still in hospital, Ms B wrote to "the Manager" of Lester Heights, outlining her observations and concerns in relation to the care her mother received while a resident at Lester Heights. Ms B concluded her letter with the following comments:

> "We have always known that one day Mum's diseased kidney would fail but never imagined it would happen because of (apparent) negligence.
>
> To have to move her from a rest home where she was professionally and lovingly looked after was hard enough. To have her at death's door after just three days in a facility that supposedly delivers hospital-level care, is deeply distressing."

111. Radius responded to Ms B, advising that it had completed an investigation into her concerns. Radius noted the following points:

- The EN and RNs involved with Mrs A's care confirmed that a timely nursing assessment was not completed on the day of her admission.
- Radius is concerned with the failure by the RN to provide Ms B with Dr J's contact number when requested on Thursday.
- Radius has comprehensive policy and procedure guidelines to inform and direct staff in the provision of service delivery. It is a requirement that all staff adhere to these policies and procedures to ensure high standards of care are delivered and maintained.
- The HCAs made appropriate verbal and written observations pertaining to Mrs A's fluid intake.
- The EN who admitted Mrs A was satisfied with the verbal and written handover received from the caregiver from the previous rest home. She therefore did not seek additional information from Ms B. However, Radius agrees with Ms B that it is important for staff to meet with new residents and their family to explore clients' needs and requirements.
- Radius is sincerely sorry for the distress and anxiety this situation has caused Ms B and other family members.

112. Radius emailed Ms B and advised that it believed "the lack of strong clinical leadership, oversight and coaching of RNs [by Ms D] has impacted [on] this situation significantly and we are both very disappointed and regretful of the outcome this had in relation to your mother."

Ms D

113. Ms D registered as a nurse in 1998. She was employed as charge nurse at a rest home for eight months in 1999/2000; this was followed by two years working at Lester Heights, and nearly four years at a hospital, both in the role of RN. From March 2006 to February 2007 Ms D was employed as a supervisor at another rest home.

114. Ms D returned to Lester Heights as an RN in February 2007. In June 2008 Ms D accepted the role of CNM at Lester Heights.

115. Radius advised HDC that while it did not have a specific orientation and self-directed learning package for the role of CNM in place at the time of Ms D's appointment, it provided Ms D with "a very good level of orientation and support to ensure she had every opportunity to succeed and develop professionally and proficiently within her role as Clinical Manager." Radius advised that Ms D worked through a "comprehensive checklist" with their Operations Manager and a Facility Manager,[26] and she also spent two full days at another Radius rest home, receiving orientation from the Clinical Manager and Facility Manager there.

116. Radius further advised that Ms D attended preceptor[27] study days in July and September 2008, and that its Operations Manager "availed herself at regular site visits and by phone to ensure ongoing clinical management support and coaching was provided, however this was never actively sought by [Ms D]".

117. Radius's view is supported by Ms C, who advised HDC that when Ms M or Ms L were on site, they took the time to speak to Ms D and offer her support. In contrast, Ms D advised HDC that she was "never offered support" and she was "hardly spoken to at all".

118. Radius noted Ms D's previous experience at two rest homes as a charge nurse and supervisor, where it believes she was required to provide a similar level of clinical leadership, support, and coaching to staff as her CNM role at Lester Heights required.

119. Ms C advised HDC that "there were ongoing issues [with Ms D's performance] from the end of 2008". Email correspondence between Ms C and Ms L on 31 December 2008 shows that Ms C had concerns with poor clinical care and documentation by the RNs and Ms D, and the oversight provided by Ms D. She planned to meet with Ms D the following week to discuss her concerns and develop an action plan to address the poor standard of documentation, wound equipment and processes, rosters, and out of

[26] Radius provided HDC with a copy of the orientation checklist from its self-directed learning package for RNs. The self-directed learning package requires the RN to answer questions on a range of topics and encourages the RN to learn by asking questions and reading the policy and procedures manuals.

[27] A "preceptor" is a teacher or instructor. In the field of nursing, it means an expert or specialist nurse who gives practical experience and training to a newly registered nurse.

date morphine. As part of the action plan, Ms C asked Ms D to keep a written account of what she did each day, and requested daily/weekly meetings with her. She also reminded Ms D that the role of CNM "goes beyond Monday–Friday 7–3pm". Ms D advised HDC that she was not told there were issues with her performance, and Ms C's account of action taken is "not true".

120. Email correspondence between Ms C, Ms L, Ms D and Ms M from March 2009 to the time of Mrs A's admission shows that Ms C identified problems with Ms D not understanding her role and responsibilities as CNM, in particular: a lack of knowledge of clinical, quality, medication and health and safety manuals; lack of understanding of her role in supporting staff who are feeling unsafe; and not taking responsibility for poor standards of documentation (documentation that was either incomplete or missing entirely). Other issues that were discussed with Ms D included the need for her to cover enough shifts "on the floor" to keep up her clinical hours; and alerting her to the fact that RNs were calling the ED for clinical information as their first port of call.

121. Ms D told HDC that there was no discussion with her about covering enough shifts on the floor to keep up her clinical hours.

122. On 11 March 2009, Ms L said in an email to Ms C that she would discuss her concerns about Ms D's documentation with Ms D the following week. Ms L added that the discussion would be informal at that stage but she would be making it clear to Ms D that formal discussions may follow if needed.

123. On 8 April 2009, Ms L noted in an email to Ms D that "[c]omments from the audit report (3.1) suggest you don't have the knowledge expected which does concern me, & may result in a formal process being instigated". Ms L advised Ms D in the email that if she had any queries about the expectations of the Clinical Manager role she should discuss these with Ms C or the Facility Manager at one of Radius's other facilities.

124. Minutes of weekly meetings between Ms D and Ms C are documented from 9 April through to 5 June 2009.

125. On 9 April 2009, Ms C documented that she was meeting with Ms D to discuss the issues raised in Ms L's email about Ms D's "competency". Ms C's minutes state that "[s]erious issues have been raised" and that she had reviewed the Clinical Manager job description with Ms D. Ms C also documented in the minutes that she "offered support — [Ms D] needs to up clinical leadership on the floor. How can I support you in this role". Ms C documented her suggestion that an action plan be implemented, which would include "reading [Radius's] policies. Time management. Documentation". It was noted that support from another CNM was available. The minutes also state: "Family meetings — clinical leadership of RNs and other staff part of [CNM] role. [Ms D] not happy to babysit RNs as they have degrees."

126. Ms D told HDC that the meeting on 9 April "never happened", and that she never said that she was "not happy to baby-sit RNs as they have degrees".

127. On 9 April 2009, an action plan was put in place to help Ms D in her role. Ms C noted in her email to Ms L that the action plan "will be a working document that will be reviewed on a weekly basis to keep [Ms D] on track and to ensure follow up".

128. On 27 April 2009, the weekly meeting minutes state: "Review CNM action plan with [Ms D] — reading through [Radius's] manuals — hard going with some."

129. On 1 May 2009, the weekly meeting minutes state: "Concerns re documentation and [Ms D] following through with CNM action plan — will use email to convey follow up." On the same day Ms C emailed Ms D noting that they needed to "revisit" her action plan and the clinical notes audit.

130. On 12 May 2009, the weekly meeting minutes note the following points under "Action plan": reading manuals, scabies outbreak management folder, facility checklist reviewed.

131. There is no evidence of any further discussions with Ms D in relation to the action plan.

132. Further concerns were noted with Ms D's performance in mid 2009. On 13 July 2009 Ms C emailed Ms L stating that she "would be having words" with Ms D in relation to her failure to roster sufficient staff over the weekend, despite Ms D being aware that this was an issue when reviewing the roster with Ms C on Thursday.

133. On the day of Mrs A's arrival, Ms C emailed Ms L noting several concerns with Ms D's performance, including lack of clinical leadership for the new graduate RNs, and inadequate wound management documentation. The poor standard of documentation was thought to be due to Ms D "not showing any clinical leadership" and "staff following [Ms D's] example". Ms C noted in her email that Ms O (a Facility Manager at another Radius facility) had made herself available to meet with Ms D and Ms C the next day to "offer her vast experience to support [Ms D] in her role as CNM". Ms C advised Ms L that "[w]e are aiming to show [Ms D] a better way of being a support to me in my role, the staff clinically — based on her job description. At this stage it is an informal meeting."

134. Ms L responded to Ms C's email the same day, stating: "I think you now need to make it quite clear to [Ms D] that she has had opportunities to improve and this will be her final one before disciplinary action is taken."

135. On Tuesday, Ms O advised Ms L by email that she had spoken with Ms D about a number of issues and advised Ms D that she would be glad to discuss them with her if she wished. Ms O also offered Ms D "support in the clinical role" which she would keep confidential (unless it involved the clinical care of a resident, in which case she would need to inform Ms C).

136. On Tuesday, Ms L wrote in an email to Ms C that "we have proof [Ms D] is not performing to standards expected & she has to take responsibility for her failings &

stop blaming others". In the same email Ms L stated that she fully supported Ms C and what she was doing, and that she had "the utmost faith in [Ms C's] ability".

137. A few days following the death of Mrs A, Ms D emailed Ms L and Ms M advising them of her decision to resign. Ms D stated in her email:

> "I really enjoy my job and know that I am a good nurse and do this job well when given the support that is necessary. Unfortunately that support has not been there for a long time and instead I am being undermined and no longer feel safe working at Lester … I cannot stay in a workplace where I am treated with disdain, hostility, and a complete lack of respect by my manager. This is workplace bullying of the worst kind, and has now left me with no alternative but to resign as all attempts to have the situation resolved have been unsuccessful … I have today given my written notice to [Ms C] [Facility Manager] …"

138. Radius advised HDC that prior to tendering her resignation, Ms D did not raise any concerns with either Ms C or Ms L in relation to the lack of support she felt she was receiving from management. In contrast, Ms D advised HDC that she repeatedly tried to raise her concerns with management about the lack of support she was receiving, and she once emailed the CEO of Radius. She advised that she never received any responses to her emails. Ms D was unable to provide HDC with evidence of these emails.

139. Ms D advised HDC that she "knew nothing" about the concerns about her performance in her role as CNM until after Ms B's complaint was made.

140. Radius management met with Ms D to discuss "a number of concerning clinical issues". A final written warning was issued to Ms D a few days later, stating that "there have been serious shortfalls in the quality of clinical care at Lester Heights under your leadership as Clinical Nurse Manager, specifically poor documentation, poor communication, inadequate admissions procedure and poor supervision. This has had the effect of leading to an inadequate level of patient care and of putting patients at risk."

141. Ms D left Lester Heights shortly afterwards.

142. Ms D advised HDC that she had instructed all nursing staff to report to her any concerns that they could not deal with, and that no such concerns were ever brought to her with regard to Mrs A.

143. In response to questions regarding the overall poor adherence to policies and procedures, and her role in ensuring staff were adhering to policies and procedures, Ms D advised HDC, "I made the mistake of trusting my RNs to do their jobs." Ms D later accepted that she "should have been more vigilant" and she is "sincerely sorry for the outcome".

144. On 28 September 2009, Radius wrote to the Nursing Council of New Zealand (NCNZ), outlining a number of concerns it had regarding Ms D's competence. These included

issues surrounding inadequate clinical supervision and leadership, lack of compliance with clinical documentation requirements, and failure to refer residents to a dietitian or physiotherapist where indicated. For example, following Ms D's resignation it was found that a resident who had lost 15 kilograms over 12 months had not been referred to a dietitian, and there continued to be problems with documentation several months after being identified as an issue in April 2009. NCNZ requested details of Ms D's professional development and orientation, and copies of her performance appraisals while employed by Radius. Radius provided Ms D's professional development and orientation information but was unable to provide any performance appraisals for Ms D.

Ms C

145. Ms C advised HDC that prior to Mrs A's death, no concerns had been raised with her about her management of the facility, and she provided HDC with copies of her performance review, a pay increase letter and emails, all of which are positive about Ms C's performance.

146. Ms C's performance review dated 28 October 2008 states: "[Ms C] is very supportive of staff, & although not an RN is able to manage professional judgements within her scope of practice."

147. Under the heading "Supervision of Nursing Management/Care Delivery" it states: "[Ms C] is aware of RRC policies & procedures & oversees implementation by RNs …"

148. On 6 May 2009 Ms C received a pay increase. The letter from Radius's CEO states: "[Ms C], I would like to take this opportunity to thank you for your professionalism and dedication to your role as Facility Manager. It is encouraging to have people of your calibre in the company and we look forward to another great year working with you."

149. On Tuesday, Ms C received an email from Ms L which stated: "I fully understand how you must be feeling with [Ms D]. However, I fully support you & what you are doing … I have expressed my concern to [Ms M] about your workload — from experience I know how difficult it is to run more than one facility … Please let me know what I can be doing to support you better — I do have the utmost faith in your ability & would hate you to feel that stressed with everything you decide to find work elsewhere …"

150. Ms C advised HDC that Mrs A's death was personally devastating for her and she feels deeply for Mrs A's family and their loss. Ms C advised HDC that she thought she had done as much as she could to improve the standard of care being provided at Lester Heights, to promote pride in the staff who worked there and to encourage staff to take clinical responsibility for their own practice and the care they were providing.

151. Ms C told HDC that she felt supported by her managers (Ms L and Ms M), who were always available to her on the telephone and visited the facility on a regular basis.

Ms E

152. Ms E registered as a nurse in the seventies and spent some time working as a sole charge nurse overseas. She commenced employment at Lester Heights in 2006, but has worked at other Radius facilities since 2003.

153. RN Ms E advised HDC that she first became aware of Ms B's concerns regarding her mother's health on Thursday afternoon.

Registered nurses

154. Radius advised HDC that all RNs are provided with a comprehensive orientation on employment, including a self-directed learning package. Radius also advised HDC that it "provides a comprehensive In-service Training Programme which exceeds requirements of Health and Disability Sector Standards and DHB Contract requirements".

155. In addition, Radius advised that standardised policies, procedures and clinical guidelines are available at all its facilities, together with ongoing clinical support and coaching for all clinical staff, which it expects the CNM to provide.

Radius's response to complaint

156. Radius advised HDC that it is the responsibility of the Facility Manager and CNM to ensure staff are familiar with its policies and procedures, and it was disappointed that this responsibility was not met.

157. Radius is "deeply concerned and disappointed" by the failure of its RNs to respond appropriately to the concerns raised by the HCAs and Ms B, and for their lack of timely communication with Dr J. Radius advised that the RNs are required to supervise and coach HCAs to ensure the care provided is appropriate, effective, and timely. Radius advised that it is not clear why the RNs failed to act on the information provided by the HCAs or the concerns raised by Ms B, but went on to say that it believes Ms D, as CNM, did not provide the appropriate level of leadership, support, or coaching required for the RNs to effectively co-ordinate, plan, and monitor care of residents.

158. In response to concerns raised by Ms B's complaint in relation to the admissions process, care planning, fluid intake, and communication with the GP, a meeting was held with the RNs on 2 September 2009.

159. The minutes from this meeting note: "RNs must ensure all residents with identified medical risks, concerns and changes in condition are promptly followed up i.e. assess resident and discuss with GP for further care requirements. Clinical Manager on morning duty to facilitate all new admissions, complete initial documentation and allocate resident to an RN for primary care responsibility. Discussed fluid requirements of residents as part of assessment and planning care and what to do for 'at risk residents' e.g. start fluid balance chart, daily/weekly weigh, physical assessment to check for signs of fluid overload/dehydration, liaise with GP to keep updated. Referred to Nutrition and Hydration P&P, education handout provided and discussed."

160. Radius acknowledged that the fluid balance charts were "poorly completed by all staff". On 23 September 2009 and 10 March 2010, staff received in-service education on Nutrition and Hydration, including the use of fluid balance charts. Radius introduced two simplified food and fluid charts in addition to the standard fluid balance chart. With regard to an error on the fluid balance chart template, which makes accurate documentation of information difficult, Radius advised HDC that the chart will be reviewed and amended. Radius also acknowledged that overall, the standard of documentation by the RNs was "inadequate".

161. Radius advised that subsequent to this complaint, clinical operational oversight has increased to ensure appropriate standards of care are provided and maintained. Radius advised that the Regional Managers and Operations Managers now undertake comprehensive site audits on a regular basis to ascertain a facility's level of compliance with Health and Disability Standards, DHB contractual obligations, and its systems and processes.[28] This is in addition to the internal quality audits that were already in place prior to Mrs A's transfer to Lester Heights. Radius advised that this process enables deficits in core service areas to be identified and ensures that corrective actions are implemented in a timely manner.

162. Radius also told HDC that, as well as changing ownership in 2010, it has had "significant leadership and management changes ensuring there is increased support, mentoring and coaching in the facilities". For example, it has appointed a new Facility Manager at Lester Heights who is an RN and has previously worked in a Clinical Manager role. It has also appointed two new Regional Managers "whose clinical knowledge and focus has provided significant expertise into how care is delivered at the coalface". Radius also advised that it is appointing a Quality Co-ordinator to review all quality systems.

163. Radius expressed deep regret "at the sequence of events that occurred in relation to the lack of appropriate and timely nursing care provided to Mrs A by the Registered Nurses and Management of Radius Lester Heights Hospital". Radius extended its sincere apologies for the deficiencies in care and service delivery provided to Mrs A and for the additional concern and anxiety experienced by Ms B as a result.

Follow-up actions in response to provisional report

164. In my provisional report, I recommended that Radius apologise to Mrs A's family for its breaches of the Code. I also recommended that Radius reinforce its policies/procedures in relation to the following matters:

- All RNs be required to document their observations, assessments and care provided in the resident's progress notes for the first 48 hours of a resident's admission.

- All staff be required to document in residents' progress notes any follow-up action taken or outcome reached in response to family concerns.

[28] Radius provided HDC with copies of these audits from July 2010 to February 2012.

- Whenever a family member raises concerns, as well as being documented, these should be brought to the attention of the RN and CNM as soon as possible, and be responded to in a timely manner.

- Preceptors and buddies to receive ongoing training for that role, to ensure they are teaching best practice and adhering to policies and procedures.

165. On 31 May 2012, Radius sent Ms B a written apology for the substandard level of clinical care it provided to her mother.

166. Radius provided HDC with a copy of its updated Clinical Records Policy and Procedure, which specifically requires an RN to document observations, assessments and care provided in the first 48 hours post admission. This policy still includes a requirement to document contact with family.

167. Radius also provided HDC with a copy of its Compliments and Complaints Policy and Procedure. The Compliments and Complaints policy also stipulates a process for escalating "written or verbal expression[s] of dissatisfaction" to the Facility Manager and ensuring those complaints are responded to within five working days.

168. Radius advised HDC that it was working to improve preceptor refresher courses and provided HDC with a copy of its "Preceptorship Framework". The stated aim of this framework is to "ensure all registered nurses and health care assistants are supported professionally through the Radius Care Preceptor Framework". It includes sections on preceptorship for newly employed RNs and ENs, ongoing peer support/clinical supervision for RNs and ENs; and buddying for newly employed health care assistants. Radius advised HDC that "buddy training"[29] is ongoing, and support for all staff is a focus. It also advised that as preceptor refresher courses are not readily available, it is working with a doctor to improve it preceptorship programme.

169. Radius advised HDC that "maintaining best practice and applying the Policies and Procedures as is required of staff is a never ending goal from Radius as a whole, the Regional Managers and Facility Managers". Radius advised that its regular internal and external audits have enabled it to ensure that it is continually improving.

[29] In Radius' Preceptorship Framework, "buddying" is defined as a senior health care assistant who has been given formal responsibility to support a newly employed health care assistant through buddying.

Standards

Competencies for registered nurses[30]

Domain one: professional responsibility

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

Domain two: management of nursing care

- Competency 2.1: Provides planned nursing care to achieve identified outcomes.

- Competency 2.3: Ensures documentation is accurate and maintains confidentiality of information.

    - Indicator: Maintains clear, concise, timely, accurate and current client records within a legal and ethical framework.

Competencies for nurses involved in management

- Promotes a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.

Domain four: interprofessional health care & quality improvement

- Competency 4.1: Collaborates and participates with colleagues and members of the health care team to facilitate and co-ordinate care.

Health and Disability Sector Standards NZS 8134.1.2: 2008

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

Opinion: Breach — RN Ms D

170. Ms D was employed by Radius to work at Lester Heights as CNM "for a minimum of 24 hours per week". Ms D was responsible for roster management, and rostered herself on as CNM for the four days Mrs A was a resident at Lester Heights.

171. As CNM, Ms D had ultimate responsibility and oversight for clinical operations. She was responsible for leading, supporting, and training the RNs and HCAs, and for ensuring staff were complying with their job descriptions and Radius's policies and procedures. She was also expected to act as a role model to staff by personally

[30] This document was first published by the Nursing Council of New Zealand in December 2007. It can be found at www.nursingcouncil.org.nz.

maintaining excellent standards of clinical care and adhering to all Radius's policies and procedures.[31]

Initial Assessment/Care plan

172. Radius's policy requires the RN responsible for admitting a new client to complete the Initial Assessment/Care plan during the shift on which the client is admitted.[32] As CNM, Ms D had a responsibility to ensure Mrs A was admitted by an RN in accordance with policy.

173. Although Ms D had rostered herself on as CNM on the day of Mrs A's arrival, she was the only qualified RN working at the time of Mrs A's admission. However, Ms D advised HDC that she did not admit Mrs A to Lester Heights; EN Ms I admitted her.

174. My expert advisor, Ms Brady, advised that while Ms D could have directed EN Ms I to assist with the admission procedures, overall responsibility for Mrs A's admission lay with Ms D as the only RN working at that time. I agree. Accordingly, Ms D was responsible for ensuring the Initial Assessment/Care plan was adequately completed.

175. The Initial Assessment/Care plan was only partially completed. In particular, Mrs A's weight, breathing pattern and falls risk were not recorded, and the level of activity of each section (eg, independent, needs assistance, or dependent) has not been completed at all. The document has not been signed or dated by the person completing the form.

176. Ms Brady notes that if staff were relying on the Initial Assessment/Care plan alone to provide care for Mrs A, they would not have had sufficient information to meet all her needs.

177. By failing to ensure Mrs A was admitted in accordance with Radius's policy, and failing to ensure that the Initial Assessment/Care plan was adequately completed, Ms D failed to comply with Radius's Initial Assessment, Care Planning and Review Policy and Procedure, the Radius CNM and RN job descriptions,[33] and NCNZ's Competencies 1.3 and 2.1.

Communication of the fluid balance chart

178. Ms D advised HDC that she "instructed staff on the floor to start a [fluid balance chart]". A fluid balance chart was subsequently commenced on Tuesday morning, but it is unknown by whom.

179. Radius's policy requires a hydration assessment to be conducted upon admission of a new resident.[34] If a resident is at risk of dehydration, a fluid balance chart must be commenced, the medical officer notified, and a hydration assessment completed each duty by clinical staff.

[31] CNM Job Description.
[32] Assessment, Care Planning, and Review Policy and Procedure.
[33] The RN job description requires the RN to develop an initial care plan within 24 hours of admission.
[34] Nutrition and Hydration Policy and Procedure.

180. Staff at Lester Heights must record each assessment, event, visit, treatment, intervention, procedure, and consultation in the resident's progress notes as soon as practicable after it has occurred.[35] New treatments and incidents must be reported at the handover.[36]

181. As the person responsible for commencing a fluid balance chart, Radius's policies required Ms D to notify the other RNs about the hydration assessment and fluid balance chart, both by documenting in the progress notes and handover sheet, and by verbally notifying them. The RNs relied on having information about the existence of the fluid balance chart communicated to them as it is kept in the nurses' station, separate from the resident's notes.

182. There is no evidence of written or verbal communication from Ms D to Dr J or the other RNs about the commencement of a fluid balance chart for Mrs A. As noted by Ms Brady, had Ms D ensured Dr J and the RNs were informed about the fluid balance chart, the RNs would have known to conduct a hydration assessment each shift in accordance with policy, and it is likely that Dr J and the RNs would have been alerted to Mrs A's low fluid intake before Thursday evening.

183. By failing to ensure that Dr J and the RNs were advised about the fluid balance chart for Mrs A, Ms D failed to comply with Radius's policies. She also failed to comply with NCNZ's Competency 4.1.

Clinical oversight — monitoring, assessment and documentation

184. As CNM and an RN, Ms D was required to ensure that excellent standards of clinical practice were implemented,[37] and to promote an environment that supported nurses' abilities to provide safe, effective and ethical nursing practice.[38] The important role of a CNM in providing leadership and oversight to staff in a rest home environment has been the subject of previous HDC reports.[39]

185. Other than the care provided to Mrs A by RN Ms F during her initial medical assessment on Tuesday afternoon, there is no documented evidence of the RNs assessing Mrs A, or acting on signs of deterioration in Mrs A's health status. My expert advisor, Ms Brady, considers that the monitoring and assessment by the RNs was inadequate.

186. The fluid balance chart was poorly filled out by the HCAs. Mrs A's fluid intake was not totalled after 24 hours, and while the "fluid output" column has been filled out on two occasions, these appear to actually refer to the amount of fluid that Mrs A had drunk, rather than the output of urine. The RNs were also individually responsible for

[35] Clinical Records Policy and Procedure.
[36] Handover of Client Care Between Duties Policy and Procedure.
[37] CNM job description.
[38] "Competencies for registered nurses" at the end of Domain two: "Competencies for nurses involved in management".
[39] See Opinions 08HDC17105 and 07HDC17647.

the oversight of the fluid balance chart and for supervising and coaching the HCAs regarding filling it in.[40]

187. The RNs who cared for Mrs A deny being informed verbally at handover of any concerns about Mrs A. Despite the apparent lack of verbal handover, concerns about Mrs A's oral intake were clearly documented by the HCAs on more than one occasion in Mrs A's progress notes. All RNs deny being aware of these concerns, which leads me to conclude that they did not read Mrs A's progress notes, in contravention of Radius's policy.

188. There is a consistent lack of documentation by the RNs during the time Mrs A was a resident at Lester Heights. Over a four-day period, there are only two instances where an RN has documented information about Mrs A. Staff at Radius had clear obligations to document frequently, comprehensively and accurately.[41] The minimum requirement was to document each patient contact, or one entry per shift, whichever was more appropriate. Furthermore, documentation is a basic requirement of each RN.[42]

189. The failure by all six RNs to appropriately monitor and assess Mrs A, communicate with other staff, and document in accordance with policy demonstrates a lack of clinical leadership or oversight by Ms D. There is no evidence to support Ms D's assertion that she had identified those deficiencies or taken steps to remedy them.

190. Ms D took a passive approach to her role as CNM. She advised HDC that she instructed the RNs to report to her any concerns that they could not deal with and that she "made the mistake of trusting [her] RNs to do their jobs". However, Mrs A was a new resident with several co-morbidities. A high level of clinical oversight is particularly important in circumstances such as these, to ensure that any changes in a resident's condition can be identified and responded to in a timely manner. As CNM, Ms D needed to take a more proactive role in overseeing the care provided to Mrs A to ensure the care being provided was safe, and co-ordinated, and in accordance with Radius's policies and procedures.

191. Ms D's failure to identify and act on the poor standard of clinical care provided to Mrs A was in contravention of her job description, and NCNZ's Competency 1.3.

Summary

192. In her role as both RN and CNM, Ms D failed to comply with a number of Radius's policies and procedures. She also failed to meet the requirements of her job description and the competencies of an RN.

193. Ms D did not ensure that Mrs A was admitted to Lester Heights in accordance with policy, and that her Initial Assessment/Care plan was adequately completed.

[40] RN job description.
[41] Clinical Records Policy and Procedure.
[42] See NCNZ's Competency 2.3. In addition, the RN job description required the RNs to keep clear, concise records.

194. Ms D did not communicate her decision to put Mrs A on a fluid balance chart to the other RNs and Dr J. Ms D's failure to communicate this information created an obstacle to the provision of continuity of care, as concerns about Mrs A's fluid intake and the consequent need for closer supervision were not brought to the RNs' and Dr J's attention.

195. In her role as CNM, Ms D failed to provide adequate supervision and clinical oversight to staff. All six RNs who cared for Mrs A failed to document (or document adequately) in her progress notes, follow up the HCAs' concerns regarding Mrs A's fluid intake, or adequately monitor Mrs A over the course of a four-day period. There is no evidence to suggest that Ms D was taking action to remedy these problems, or that she was even aware of them.

196. I appreciate that each individual staff member is responsible for providing care in compliance with professional standards, their job description, and Radius's policies and procedures. However, this investigation has identified non-compliance and failings in several areas by all six RNs who cared for Mrs A. In light of widespread and common failures, attention turns to the person responsible for ensuring the RNs, EN and HCAs were complying with policies and job descriptions, and for taking remedial action where it was not — Ms D. In view of this important responsibility, it was not reasonable for Ms D to simply "trust [her] RNs to do their jobs". Ms D needed to be more proactive to ensure that the RNs were keeping her informed, communicating to the staff, and documenting in the progress notes.

197. By failing to admit Mrs A to Lester Heights in accordance with policy, failing to ensure other staff were informed that Mrs A was on a fluid balance chart, and failing to provide an adequate level of leadership and oversight to the HCAs, EN and RNs, Ms D did not provide services to Mrs A with reasonable care and skill and accordingly breached Right 4(1). She also failed to provide services that complied with relevant standards and, in doing so, breached Right 4(2) of the Code.

Opinion: Breach — Radius Residential Care Ltd

198. Mrs A was transferred to Lester Heights as her health had deteriorated to a point where she required hospital-level care. She had the right to expect that Lester Heights and its staff would carry out appropriate assessments; closely monitor her health; communicate effectively with each other, Mrs A and her family, and Dr J; and take prompt action once her condition began to deteriorate. As outlined above, the care provided to Mrs A did not meet the required standard.

199. I have carefully considered the extent to which the deficiencies in Mrs A's care occurred as a result of individual staff action or inaction, as opposed to systemic and organisational issues. In my opinion, Radius failed to meet its duty of care to Mrs A in two respects. First, it failed to ensure a staff culture of compliance with its policies and

procedures; and, secondly, it failed to respond decisively and promptly enough to concerns raised about Ms D's performance.

Culture of non-compliance

200. The problems that arose with Mrs A's care were not the result of isolated incidents involving one or two staff. There were six RNs, one EN, and several HCAs involved in Mrs A's care over the four days she was a resident at Lester Heights. I am concerned that many of the shortcomings were common to a number of staff. This pattern suggests that either Radius's policies and procedures were inadequate, or that Radius failed to ensure staff were following the policies and procedures.[43]

201. I acknowledge that, for the most part, Radius's policies and procedures appear to be satisfactory. Accordingly, the gap appears to be in Radius's systems for ensuring staff were complying with those policies. Without staff compliance, policies become meaningless. Ultimately, Radius had a responsibility to ensure that all staff complied with policies and provided services of an appropriate standard.[44] As stated in a previous report:[45]

> "[t]he inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that does not sufficiently support and assist staff to do what is required of them. [The rest home] as an organisation must bear overall responsibility for this."

202. When the condition of a patient deteriorates, there is a need for more frequent assessments, clinical observations, medical reviews and communication with family members. Such situations are foreseeable in a facility that provides hospital-level care, and the management of such patients requires significant co-ordination.

203. As owner of Lester Heights, Radius has overall responsibility for ensuring its policies are complied with, and that the care delivered is timely, appropriate and safe.[46] Further, as an employer, Radius must take responsibility for ensuring appropriate care is provided by its staff. I do not consider that Radius fulfilled its obligations in this regard.

Response to concerns raised about Ms D

204. When Mrs A arrived at Lester Heights, Ms D had been employed in the role of CNM for approximately 13 months.

205. Ms D states that she was not told of issues with her performance until after Ms B's complaint was made. However, it is clear that Radius was on notice of concerns with Ms D's performance from late 2008. Email correspondence between Ms C and Ms L in December 2008 describes Ms C's concerns with the standard of documentation and clinical care that the RNs and Ms D had provided to a resident.

[43] This issue has previously been commented on in Opinion 07HDC16959 (20 May 2008), p18.
[44] Opinion 08HDC17309 (26 May 2010) p23.
[45] Opinion 09HDC01783 (28 March 2011) p 23.
[46] This is required by Right 4 of the Code and also Standard 2.2 of the Health and Disability Sector Standards.

206. The concerns with Ms D's performance persisted. In March 2009, concerns were identified with Ms D's documentation and, in April 2009, Radius was informed of "serious issues" with Ms D's "competency". Between April 2009 and the time of her resignation, Radius was aware of concerns with Ms D's performance in areas that go to the very heart of the CNM role, in particular poor clinical leadership and supervision, inadequate knowledge of Radius's policies and procedures, and poor standards of documentation.

207. It has been stated in a previous report:[47]

> "Hospitals must have in place a clear mechanism for dealing decisively with concerns about an employee's competence. […]
>
> [I]f a hospital has (or, in light of the information available to it, should have) reason to believe that a clinician may pose a risk of harm to patients, it has a duty to respond immediately to minimise the risk."

208. In my view, these comments are also applicable to rest homes and the care provided to its residents by RNs. I recognise that there can be tension between following due process when taking disciplinary action against an employee, and safeguarding patients. However, as noted in a previous report,[48] a DHB's (or in this case a rest home's) first duty must always be to safeguard its patients.

209. The residents at Lester Heights are vulnerable, with some requiring hospital-level care. The interests of residents in rest homes are better served if issues relating to competence are dealt with thoroughly and expeditiously before they escalate and residents are harmed.[49] Given the serious nature of the concerns raised in April 2009, Radius needed to take prompt and decisive action to ensure Ms D was providing competent care to Lester Heights residents.

210. There is evidence that Ms C and Radius management took some steps to address these concerns. For instance, Ms L spoke to Ms D on two occasions (December 2008 and 11 March 2009) about her documentation. On 8 April 2009, Ms L emailed Ms D, "concerned" that she "doesn't have the knowledge expected" and advised her where she could seek advice and support if she had any queries about the expectations of the CNM role.

211. On 9 April 2009, Ms C put an action plan in place to address issues with Ms D's performance that she identified as needing attention. Ms C followed up on the action plan regularly until 12 May 2009, and kept Radius management updated with what she was doing to support Ms D to meet the requirements of her role.

212. On the day of Mrs A's arrival, Ms C alerted Radius management to several serious concerns about Ms D's performance, and advised Radius that a manager from another

[47] Opinion 04HDC07920 (18 February 2005), p 40.
[48] Opinion 04HDC11624 (4 April 2006), p 20.
[49] Opinion 04HDC07920 (18 February 2005), p38.

facility had made herself available to meet with Ms D and Ms C the next day to "offer her vast experience to support [Ms D] in her role as CNM". Ms C advised Radius management that "[w]e are aiming to show [Ms D] a better way of being a support to me in my role, the staff clinically — based on her job description. At this stage it is an informal meeting." Radius expressed approval and support for the work Ms C was doing to assist Ms D to meet the expectations of her job description.

213. I acknowledge that Ms C was proactive in addressing the concerns with Ms D's performance. However, Ms C was not an RN, and was therefore limited in her ability to assess the standard of clinical care and supervision being provided by Ms D.

214. All discussions and meetings with Ms D prior to her resignation were of an informal nature. It appears that the first time Radius formally raised its concerns with Ms D was at a meeting after the death of Mrs A. It is evident from Radius's letter to the NCNZ, dated 28 September 2009, that further issues with Ms D's standard of clinical care and oversight were not identified until after Ms B's complaint had been received.

215. Radius clearly had reason to believe that Ms D's practice was suboptimal, and therefore had a duty to respond immediately to minimise the risk to residents' safety. In my view, informal discussions were not enough to address the issues.

216. The lack of appropriate corporate response in April 2009 meant that by the time of Mrs A's admission, a serious situation had developed. Radius allowed an employee about whose competence it had concerns, in a position of clinical leadership, to continue practising without taking sufficient steps to ensure that those concerns were adequately addressed. Radius should have arranged ongoing oversight by an experienced CNM to ensure all issues were identified and appropriate action taken to address them. It should also have arranged for Ms D to complete an educational/re-training programme to assist her in functioning at the level required by her job description.

217. Radius's inadequate response to serious performance concerns about a person in a position of clinical leadership is unacceptable.

Summary

218. As owner of Lester Heights, Radius has ultimate responsibility to ensure its residents receive appropriate, timely, and safe care. By failing to ensure staff were complying with its policies and procedures, and failing to respond appropriately to concerns identified about Ms D, the person charged with ensuring that compliance, Radius did not meet its duty of care to Mrs A and breached Right 4(1) of the Code.

Opinion: RN Ms E — Adverse Comment

Introduction

219. RN Ms E was on duty on the morning shifts of Tuesday, Wednesday and Thursday. In a hospital-level facility such as Lester Heights, the responsible RN is the senior person on duty, who supervises and supports HCAs, ENs and junior RNs.[50]

Follow-up and documentation — Thursday

220. On Thursday, Ms B approached RN Ms E, concerned for her mother's health. Ms B requested a copy of her mother's blood test results and Dr J's phone number.

221. RN Ms E advised HDC that she referred Ms B's concerns to Ms D. Ms D accepts that RN Ms E told her that Ms B wanted to speak to Dr J, and wanted a copy of Mrs A's blood test results. However, Ms D advised HDC that she was not informed of any major concerns for Mrs A's well-being until she was transferred to hospital on Thursday.

222. My independent expert advisor, Glenda Brady, advised that if RN Ms E did not inform RN Ms D about Ms B's concerns for her mother, this would have been inadequate.

223. There is no documentation regarding RN Ms E's conversation with Ms B and her subsequent conversation with Ms D to assist in clarifying the conversation that took place between them. Given the discrepancy in the accounts of Ms D and RN Ms E, I cannot make a finding as to whether RN Ms E referred Ms B's concerns for her mother's health to Ms D.

224. Regardless of whether or not RN Ms E did inform RN Ms D about Ms B's concerns, Ms Brady advised that RN Ms E's response to Ms B and documentation of that discussion remained inadequate. Ms Brady commented that when Ms B approached RN Ms E with her concerns, RN Ms E should have assessed Mrs A and documented her findings and plan of care in the progress notes. I agree. Mrs A was a new resident at Lester Heights, and staff were not yet familiar with her normal level of functioning. In these circumstances RN Ms E should have taken particular care to ensure that Ms B's concerns were thoroughly investigated and the findings documented. This would also have provided Ms B with reassurance that her concerns were being heard and responded to, and it would have provided other staff with a baseline against which to gauge Mrs A's level of functioning.

225. Ms Brady also commented that RN Ms E should have documented Ms B's concerns in the Communication with Family Record form, together with details of her discussion with Ms D, in accordance with her obligations under the Clinical Records Policy and Procedure, her job description, and the standards required of her as an RN.

226. Dr J advised that it was "particularly disappointing that [Ms B] was not given my number, nor was I, at the very least, contacted by the Lester Hospital nurse(s) on duty regarding her request. A conversation at this time may have led to more timely

[50] RN job description.

intervention and earlier acute care as appropriate." Ms Brady agreed that there was inadequate communication with Dr J by RN Ms E when Ms B asked if she could speak with him about her concerns for her mother's well-being.

227. While it is acknowledged that RN Ms E may have been prevented by policy to give out Dr J's telephone number, in my view, she should have contacted Dr J about Ms B's request to speak with him, and documented her communication with Ms B in the Communication with Family Record form.

228. RN Ms E was an experienced nurse, and it is clear that she did not respond appropriately to the concerns raised by Ms B. While I do not consider that this amounts to a breach of the Code, I consider that RN Ms E should reflect on her contribution to the poor care provided to Mrs A.

Other comment

Ms C

229. Ms C was the Facility Manager at Lester Heights at the time of these events. While I acknowledge that Ms C also had a responsibility to ensure that Mrs A received a good standard of care, I did not investigate Ms C's involvement for the following reasons:

a) During Mrs A's time at Lester Heights, the CNM, Ms D, was the most senior person on site, as Ms C was working at another Radius site. In these circumstances, I do not consider Ms C can be held responsible for the poor standard of care that Mrs A received over the four-day period she was at Lester Heights.

b) While Ms C was responsible for the overall management and running of the facility from a business point of view; she was not the owner or employer of the facility, nor was she an RN. As Ms B's complaint raised concerns about the standard of clinical care that was provided to Mrs A, I decided to focus my investigation on those people who were directly responsible for the provision of Mrs A's clinical care.

Recommendations

230. I recommend that Ms D provide a written apology to Ms B and her family for her breaches of the Code. I recommend that RN Ms E also provide a written apology to Ms B for the deficiencies identified in her care. The apologies are to be sent to HDC by **5 July 2012** for forwarding to the family.

231. I acknowledge the steps taken by Radius to address the concerns Mrs A's family had about the care she received, both in response to Mrs A's initial complaint and in

response to the recommendations I made in my provisional opinion (outlined at pages 24 and 25). Radius has apologised to Mrs A's family for its breach of the Code. I am satisfied that Radius has taken action since and/or as a result of this complaint to address the issues raised and to improve the service it provides.

Follow-up actions

- A copy of this report, with the details identifying the parties removed except the name of the expert who advised on this case and Radius Residential Care Ltd (including Radius Lester Heights Hospital), will be sent to the Nursing Council of New Zealand, and it will be advised of Ms D's and Ms E's names.

- A copy of this report, with details identifying the parties removed except the name of the expert who advised on this case and Radius Residential Care Ltd (including Radius Lester Heights Hospital), will be sent to the DHB, the New Zealand Aged Care Association, the New Zealand Nurses Organisation, and the College of Nurses Aotearoa (NZ) Inc and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix — Independent expert nursing advice

The following expert advice was obtained from registered nurse Glenda Brady:

> "I (Glenda Brady) have been asked to provide an opinion to the Commissioner on Complaint: [Mrs A]. Reference: 09/01974.
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> My Professional Qualifications are:
>
> N.Z. Registered Psychopaedic Nurse — 1976
>
> N.Z. Registered Psychiatric Nurse — 1980
>
> N.Z. Registered Comprehensive Nurse — 1986
>
> My Practising Certificate Number is: 54408
>
> I have worked in Aged Care for approximately 15 years, the past year as Clinical Manager at Oakdale Resthome in Cambridge, the previous 8 years as a senior Registered Nurse at Resthaven in Cambridge. I have been involved in all aspects of nursing in these areas — including Registered Nurse on the roster, education and management roles.
>
> **Reference Material:**
> Scanned copy attached of Expert Advice Required, Supporting Information and Factual Summary of the background of the complaint (provided by the investigator).
> Enrolled Nurse Scope of practice and competencies obtained from www.nursingcouncil.org.nz
> Registered Nurse Scope of practice and competencies obtained from www.nursingcouncil.org.nz
> Health & Disability Sector Standards
>
> **Supporting Information**
- Letter of complaint to HDC (pages 1–4)
- Initial information from Lester Heights (4 December 2009) (pages 5–109)
- Notification letters to Radius and [Ms D] (pages 110–113)
- Further information from Lester Heights (15 March 2010 & 9 April 2010) (pages 114–247 and pages 416–480)
- Information from [Ms D] (pages 248–263 and pages 481–482)
- Information from [Dr J] (pages 264–266)
- [Mrs A's] clinical notes from [the] DHB (pages 267–369)
- Audit information from [the] DHB (pages 370–415)

Expert Advice Required — Radius Residential Care Ltd

1. Please comment generally on the standard of care provided to [Mrs A] by Radius Residential Care Ltd [over a period of four days in mid 2009].
2. In particular, please comment on the following:
    (a) the adequacy of [Mrs A's] initial assessment on admission and care plans
    (b) the adequacy of monitoring and assessment of [Mrs A] by the nurses
    (c) the adequacy of handover between staff
    (d) the adequacy of follow-up care/response to the concerns raised by staff and [Ms B] about [Mrs A's] condition
    (e) the adequacy of documentation (including fluid balance sheet)
    (f) the adequacy of communication with [Dr J]
    (g) the adequacy of communication with [Ms B]

3. Please comment on the adequacy of the policies and procedures in relation to:
    (a) assessment and care planning (including admission processes)
    (b) handover on shifts
    (c) staff orientation and training
    (d) nutrition and hydration

4. Please comment on the adequacy of the training provided to staff in relation to hydration and fluid balance sheets.

5. Please comment on the adequacy of systems or procedures in place to assist in the early detection of unstable or unwell patients.

6. Please comment on the adequacy of systems or procedures in place to guide staff in the appropriate clinical management of unwell or unstable patients.

7. In your view, was [Ms D] appropriately qualified and experienced for the position of Clinical Nurse Manager?

8. Please comment on the adequacy of the orientation, training, and support offered to [Ms D] by Radius Residential Care Ltd.

9. Please comment on the adequacy of the changes made by Radius Residential Care Ltd as a result of this incident.

[Ms D]

1. Please comment generally on the standard of care provided to [Mrs A] by [Ms D] [over a period of four days in mid] 2009.

2. Please comment on the level of oversight and supervision provided by [Ms D] to the nurses. In particular, was it reasonable for [Ms D] to rely on the nurses to report any concerns to her, or was a more proactive role required?

Other
Are there any aspects of the care provided by Radius Residential Care Ltd, [Ms D], or other nurses involved with [Mrs A's] care that you consider warrant additional comment?

If in answering any of the above questions, you believe that Radius Residential Care Ltd, [Ms D], or other nurses did not provide an appropriate standard of care, please indicate the severity of their departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

Medical/Professional Expert Advice
Purpose
To provide independent expert advice about whether Radius Residential Care Ltd provided adequate services to ensure [Mrs A] received an appropriate standard of care [over a period of four days in mid] 2009.

To provide independent expert advice about whether registered nurse [Ms D] provided an appropriate standard of care to [Mrs A] [over a period of four days in mid] 2009.

Background
[Mrs A] (aged 84 years) transferred to Radius Lester Heights Hospital (Lester Heights) on [Monday] 2009 (having previously resided at a local rest home for three years) as her needs had increased to the point that hospital level care was required. ([Mrs A] had been assessed by the NASC team as requiring hospital level care since February 2009 but she remained at the local rest home due to her changing abilities and the request of the family.)

[Mrs A] had only one kidney, chronic renal failure and a long history of recurrent urinary tract infections (UTI), including "permanent UTI".

On [Wednesday] 2009 [Mrs A's] daughter, [Ms B], visited her mother at Lester Heights and noticed she was shivering. [Ms B] explained to a staff member that her mother needs three layers of clothing. [Ms B] also spoke with the cook and caregivers who told her they were concerned that [Mrs A] had not eaten and would not drink her cup of tea.

On [Thursday] [Ms B] visited her mother again and noted she was still shaking and was extremely thirsty. [Ms B] became alarmed when she saw her mother's engagement ring was suddenly too big for her finger, and raised her concerns with a nurse.

[Ms B] was advised by the RN (Ms E) that a doctor ([Dr J]) had seen her mother on [Tuesday evening] and he had requested blood tests. [Ms B] asked to speak to [Dr J] but Ms E did not want to give out his personal phone number. Ms E advised HDC that she offered to take [Ms B's] contact details and pass these on to [Dr J]. [Ms B] then asked for a copy of the blood test results so she could send them to her brother in […] who is a GP, and these were provided. At this time the EN (Ms I) took [Mrs A's] pulse (96–100), blood pressure (145/75) and respiratory rate (20–22).

At 6.15pm that evening [Mrs A] was noted to be very shaky and pale. Ms I called [Dr J] who instructed hourly observations. [Mrs A] continued to deteriorate and an ambulance was called at 9.55pm. [Mrs A] was taken to [the public] Hospital where she remained until her death [a short time later]. The cause of death was acute on chronic renal failure.

[Ms B] raised her concerns with Lester Heights in a letter [after her mother had been admitted to hospital]. Lester Heights apologized to [Ms B] and advised that it had taken disciplinary action against its Clinical Nurse Manager, [Ms D].

[Ms D] resigned her position at Lester Heights [a few days after the death of Mrs A] (prior to being made aware of this complaint) and left Lester Heights [a short time later].

Complaint
[Ms B] is concerned that her mother was not formally admitted by an RN on her arrival to Lester Heights. She also questions the competency of the staff at Lester Heights, noting that it was only at her insistence that her mother's deteriorating condition was noticed.

The Commissioner has asked for comments in the following areas:

Radius Residential Care Ltd:

1. **Please comment generally on the standard of care provided to [Mrs A] by Radius Residential Care Ltd [over a period of four days in mid] 2009.**

The personal care provided to [Mrs A] during [the four days] is well documented in the Multi-Disciplinary Progress Notes (references pages 00066 to 00068) by the Health Care Assistants which also documents the fact that her oral intake was very poor and that the Registered Nurse on duty and the client's daughter had been informed of this (reference page 00067 [Wednesday] am shift). However, there is little documentation by the Registered Nurses — in fact only two entries, the first on [Tuesday] after the Medical Officer of Lester Heights, [Dr J], had completed his initial medical assessment and the second after she had been transferred to [the public] Hospital on [Thursday evening] and this entry was by a Bureau Nurse (refer to staff roster provided Page 00419).

The notification to the Ministry of Health of her admission was carried out in a timely manner; however notification to NASC and request for copy of latest assessment was not — a faxed notification of her admission was sent to the Ministry of Health on [Tuesday] (reference page 00077).

Notification of admission to NASC and request for a copy of [Mrs A's] assessment was sent [four days after] she had been transferred to [the public] Hospital (reference page 00079).

A faxed notification from Radius Lester Heights Hospital was sent to the Ministry of Health, Dr […] and email to [Dr J] advising them of [Mrs A's] death on [date] at Lester Heights is erroneous — she passed away at [the public] Hospital. (References pages 00080 and 00267).

The Registered Nurses responsibility for admission of a client is clearly documented on (Reference pages 00122–00125) Assessment, Care Planning & Review Policy and Procedure: "The Registered nurse responsible for admitting the client will complete the Initial Assessment/Care plan during the shift on which the client was admitted". This form (reference pages 00021–00022) has been on the whole completed but not dated or signed so it is unclear when and who completed this form.

[Mrs A] was seen by the Medical Practitioner — [Dr J], Medical Officer, Radius Lester Heights Hospital — for her initial medical assessment at 1710hrs on [Tuesday] after having been notified of her admission on [Monday afternoon]. This was carried out within the required time frame (reference page 00123).

Her medication was charted, blood tests ordered, medical history documented and as part of her Management plan the doctor had stated "observe for Increased SOB [shortness of breath], pain." This was not documented in her progress notes.

Overall the care provided by the health care assistants is well documented in the progress notes, including communication with the registered nurse and the daughter of the client. There is however, a lack of documentation by the registered nurses on all shifts, so it is difficult to determine the standard of care provided by them.

A fluid balance chart commenced on [Tuesday] was very poorly filled out; however it did highlight the fact that [Mrs A's] fluid intake was very low and should have alerted the registered nurses to that fact. That [Mrs A's] fluid intake and output were to be recorded on a fluid balance chart was not documented in the multi-disciplinary progress notes.

In summary, through the evidence provided to me, [Mrs A] did receive an acceptable standard of care by the health care assistants at Radius Lester Heights Hospital — attention to her every day needs of hygiene, elimination,

food and fluid intake are documented, however there is an obvious lack of education re completing a fluid balance chart.

The care provided by the enrolled nurse ([Ms I]) involved the documentation on admission in the multi-disciplinary progress notes (reference page 00066) under direction from the registered nurse to complete (reference page 00237 and Enrolled Nurse scope of practice). This involved discussion and exchange of information with the caregiver from the rest home where [Mrs A] had been transferred from. [The previous] Rest home had sent a detailed transfer form with [Mrs A] (reference pages 00103–105) which was entered in [Mrs A's] personal file.

Enrolled nurse ([Ms I]) was not on duty again until [Thursday afternoon] where she documents a change in [Mrs A's] health status (reference page 000680), her contact with [Dr J] at 1615hrs and his directions for hourly obs (observations) which I find no record of until 2140hrs. She also documents the contact with the client's daughter to advise her of the transfer to [the public] Hospital of her mother.

The care provided by the enrolled nurse includes identifying a change in [Mrs A's] health status and (without the support of a registered nurse on site) acting on the results of the recordings and observations made by contacting [Mrs A's] doctor ([Dr J]) for advice/instructions. The care she provided at that time was of a high standard.

The care provided by the registered nurses is not documented, as mentioned earlier there are only two entries by registered nurses and although the lack of documentation does not necessarily mean there was not care provided, documentation is a record of care and is in the domains of professional responsibility within the scope of practice of a registered nurse. (Reference — Registered Nurses Scope of Practice).

The policy 'Assessment, Care Planning & Review' (Reference pages 00122–00125) on page 00125 states 'The clients multidisciplinary progress notes are to reflect the daily care delivered to the client …' The Job Description of the registered nurse under the heading 'Clinical Care Delivery' has the statement: 'Residents are appropriately monitored and clear concise records kept.'

RN [Ms N] was the RN on duty on the afternoon of the first day of admission. I consider it would have been appropriate for her to have documented in [Mrs A's] progress notes. I consider that RN [Ms N's] failure to document in the progress notes is a **moderate** departure from appropriate standards.

The RN on the nocte shift [Tuesday] (RN [Ms G]) had not written anything on her shift in the notes. I consider this essential as [Mrs A] was a new admission and information on how she slept and what cares were provided to her during the night would have provided information for the next shifts and in the formation of her care plan. While I have stated that I believe it would have been

appropriate for documentation by the RN on all shifts at least for the first 24 hours since admission, there is nothing in the policy and procedures instructing this. However, considering [Mrs A's] several co-morbidities, I consider that RN [Ms G's] failure to document is a **moderate** departure from an appropriate standard.

The first entry in the multi disciplinary notes by a registered nurse was not until [Tuesday afternoon] — RN [Ms F], after the initial visit to [Mrs A] by [Dr J] — it is a very brief entry and does not document any information that she may have given the doctor on [Mrs A's] condition or any observations she had made of [Mrs A] during that afternoon shift.

RN [Ms F] was the first RN to document in [Mrs A's] notes on the second day since her admission, and while she does not document if the concerns documented by the caregivers were passed on to [Dr J], she does document his instructions. I consider this to be a **moderate** departure from acceptable standards. The caregivers had been filling in the fluid balance chart and completing progress notes documenting a poor oral intake. These notes should have been read by the RNs on duty.

[Mrs A] had several co-morbidities and had been transferred to hospital level care where a registered nurse is on duty each shift and their observations and cares should have been reflected in the progress notes.

While it is not documented in any of the policies that I have read that the registered nurse is required to document in the progress notes each shift, there has been no documentation in response to the concerns documented by the caregivers.

RN [Ms H] on nocte shift [Tuesday] and PM shift [Wednesday] also failed to document any cares or observations of [Mrs A]. Again there is no written response to the documented concerns of the caregivers and as there was a Bureau Nurse on [Wednesday night] I could only assume that she received a thorough verbal handover. I consider this to be a **moderate** departure from an appropriate standard.

RN [Ms H] stated in her response letter (Reference page 00247) that she was aware that [Mrs A] was on a fluid balance chart, yet on her two shifts did not document anything in the progress notes, and I cannot be sure if she entered anything on the fluid balance chart. If the caregivers had not documented there would be very sparse progress notes. I consider RN [Ms H]'s failure to document to be a **moderate** departure from appropriate standards.

The lack of documentation by the Clinical Nurse Manager and the registered nurses of the assessment, evaluation and plan of care for [Mrs A] I consider is a **moderate** departure from acceptable standards.

First day of admission I consider it would have been essential to have documentation in [Mrs A's] notes. I consider this to be a **moderate** departure from appropriate standards. As I have already written — the notes are a record of care and observations made and assist in the formation of the care plan.

2. In particular, please comment on the following:

(a) The adequacy of [Mrs A's] initial assessment on admission and care plans.

The Initial Assessment Care plan has been partially completed. [Mrs A's] weight and breathing pattern are not recorded. The level of activity of each section has not been completed at all. The document has not been signed or dated by the registered nurse who was responsible to assess and complete the form. (Reference page 00123 of Assessment, Care Planning &Review Policy and Procedure.)

A detailed discharge/transfer form from [the previous] Rest Home was filed on admission and would have been a valuable resource to educate the staff of her needs. (Reference pages 00103–00105).

The full multidisciplinary client assessment forms require completion within three weeks of admission — only one had been completed (reference page 00038) however there was still sufficient time to complete these (reference pages 00123–00124).

The Initial Medical Assessment had been completed within the required time frame (Reference page 00123).

If the staff were relying on the Initial Assessment Care plan alone to provide care for [Mrs A] they would not have sufficient information to meet all her needs.

I consider the lack of documentation of the Initial Assessment Care Plan a **moderate** departure from acceptable standards.

(b) The adequacy of monitoring and assessment of [Mrs A] by the nurses.

Initial baseline recordings on admission have been documented — blood pressure, pulse, temperature and respiration.

In the letter from RN [Ms F] (Reference pages 00241–002420) she states that 'I did baseline obs for Drs Round' — this was on [Tuesday] when she worked the PM shift.

There has been partial completion of the Initial Assessment Care plan (reference pages 00021–00022).

There is, on admission ([Monday]), a documented outline of [Mrs A's] medical history and care needs — information obtained from the caregiver from [the previous] Rest Home and Discharge/Transfer form from [the previous] Rest Home by the enrolled nurse [Ms I] (reference page 00067 and 000237).

On [Wednesday] there is documentation of monitoring and assessment by the enrolled nurse on duty — [Ms I] (reference page 00068).

A Fluid Balance Chart was commenced on [Tuesday] (Reference pages 00063–00064) however there is no reference to this in the multidisciplinary progress notes. These charts have not been filled in correctly or totalled after 24 hours, therefore have not been monitored correctly.

There is regular documentation by the healthcare assistants in the multi disciplinary progress notes.

There is no recorded monitoring or further assessment documented by a registered nurse in the multi-disciplinary progress notes (reference pages 00066–00068).

There is documentation of [Dr J's] visit for admission (reference page 00067) by a registered nurse.

Overall there has been inadequate documentation by registered nurses of any monitoring and assessment of [Mrs A].

As there is no signed documentation of any monitoring or assessment by all five RNs, (other than by RN [Ms F] that a urine spec was sent to the lab), I consider this to be a **severe** departure from the appropriate standard by all five RNs as a combined group. Individually:

R/N [Ms N] (pm shift [Monday] first day of admission). No documentation in Progress notes — How did [Mrs A] eat/drink, any settling routines, communication. How, other than the progress notes, is this information documented that aids in the formation of the care plan, that passes on information to the next shift? I consider this to be a **moderate** departure from appropriate standards.

R/N [Ms G] (night shift [Monday] first night since admission). No documentation in progress notes — Did [Mrs A] sleep all night? Did she have any cares during the night? Continence product change, pass urine for example. I again consider this to be a **moderate** departure from appropriate standards.

R/N [Ms E] (AM shift [Tuesday] day 2 since admission, also [Wednesday] and [Thursday]). No documented response to the caregivers notes of both [Monday] and [Tuesday] — ? No verbal report of the caregivers notes to the afternoon RN, RN [Ms F], who then could have advised [Dr J] of [Mrs A's] poor oral intake. No documented response/follow-up to the caregivers notes of

[Wednesday] or [Thursday]. I consider this to be a **moderate** departure from appropriate standards.

RN [Ms F] (PM shift day 2 since admission). Did the baseline observations that had not been done on admission the day before the doctor's rounds. She did document in the progress notes that [Mrs A] had been seen by [Dr J] for admission, however did not pass on any of the concerns documented in the progress notes by the caregivers. I consider this to be a moderate departure from appropriate standards.

RN [Ms H] (also refer to comments [about RN [Ms H] under question 1 above]) was on night duty on the [Tuesday] and PM shift on the [Wednesday] and was aware that [Mrs A] was on a fluid balance chart, yet there is no documentation on either of these two shifts in the fluid balance chart or in the progress notes. I consider this to be a **moderate** departure from appropriate standards.

The RNs state that they were not aware that a fluid balance chart had been commenced, yet the caregivers did as they [were] filling it in, they were documenting in the progress notes — the RNs do not appear to have read them or surely there would have been some response from them.

(c) The adequacy of handover between staff

There is a copy of the Daily Handover Sheet/Assistance register dated [Tuesday] in which [Mrs A's] admission has been listed and notes documented in the concerns/cares section (reference pages 00243–00245).

Reference page 00246 Today's Movements lists [Mrs A] being admitted on the [Tuesday] when in fact she was admitted on [Monday].

There is a policy 'Handover of Client Cares between Duties' Policy and Procedure (Reference pages 00126–00127).

There is no documentation in the multi disciplinary progress notes (reference pages 00066–00068) that [Mrs A] had been commenced on a fluid balance chart. This would have been the responsibility of the staff member (? [Ms D]) who commenced the fluid balance chart to communicate this both verbally and written in [Mrs A's] multi disciplinary notes and to notify the Medical Officer, [Dr J]. (Reference Handover of Client Care between Duties Policy and Procedure — Pages 00126–00127).

It is also documented in the above policy that staff commencing duty must receive both a verbal handover and are responsible for reading the multidisciplinary progress notes and care plans. If these notes had in fact been read by the RNs on duty they would have been made aware of the low fluid intake of [Mrs A] and followed the policy and procedure Nutrition and Hydration (reference pages 00157–00161) Guidelines.

There has been a failure in adhering to the Handover Policy and Procedure and important information has not been passed on and I consider this to be a **moderate** departure from acceptable standards.

(d) The adequacy of follow-up care/response to the concerns raised by staff and [Ms B] about [Mrs A's] condition.

There is repeated documentation by the healthcare assistants in the multi-disciplinary progress notes about [Mrs A's] poor oral intake (Reference pages 00066–00068) on [Monday, Tuesday, Wednesday and Thursday].

A fluid balance chart was commenced on [Tuesday] however no documentation regarding this was entered in these notes. The Communication With Family Record (reference page 00020) documents '[Mrs A's] Daughter worried about [Mrs A] Health' dated [Thursday].

In a statement from RN Ms E (Reference pages 00239–00240) she writes that on the afternoon of [Thursday] [Ms B] had approached her in the nurses' station and asked to speak to the doctor and to get a copy of [Mrs A's] blood test results. RN Ms E states that she spoke to the Clinical Care Manager about these requests; [Ms B's] concerns about her mother's health and was given permission to photocopy the blood test results for [Ms B]. There is no documentation in the multi-disciplinary progress notes about this conversation and any follow up by the RN or Clinical Care Manager of the requests and concerns expressed by [Ms B].

There has been inadequate follow-up care/response documented in [Mrs A's] multi disciplinary progress notes. I consider this to be a **moderate** departure from acceptable standards.

RN [Ms E] spoke to [Ms B] on [Thursday] and states she did offer to take her contact details and pass them on to [Dr J] and also obtained permission to give her a copy of her mother's blood test results — that it did not appear that she alerted [Dr J] of her concerns I consider to be a **moderate** departure from appropriate standards.

[Ms D] I believe did give permission for a copy of the blood test results to be given to [Ms B] but appears to have made no follow up with [Ms B] about her concerns. As CNM I would consider this to be of extreme importance and consider this to be a **moderate** departure from appropriate standards.

(e) The adequacy of documentation (including fluid balance sheet)

The fluid balance charts (Reference pages 00063–00064) are inadequately filled out; there is no totalling of intake and no record of output at all. In fact the chart has errors that would make filling it out difficult to use; for example there is a column in the output section for volume given and there is no place to record the time fluids are given.

There is no documentation in the multi disciplinary progress notes (reference pages 00066–00068) that [Mrs A] had been commenced on a fluid balance chart. This would have been the responsibility of the staff member (? [Ms D]) who commenced the fluid balance to communicate this both verbally and written in [Mrs A's] multi disciplinary notes and to notify the Medical Officer, [Dr J]. (Reference Handover of Client Care between Duties Policy and Procedure — Pages 00126–00127).

It is also documented in the above policy that staff commencing duty must receive a verbal handover and are responsible for reading the multi disciplinary progress notes and care plans. If these notes had in fact been read by the RNs on duty they would have been made aware of the low fluid intake of [Mrs A] and followed the policy and procedure Nutrition and Hydration (reference pages 00157–00161) Guidelines.

The Medication Order Sheet (Reference pages 00069–00072) including allergies and PRN (as required) medications has been completed by [Dr J], as has the Initial Medical Assessment forms (reference pages 00023–00025).

There is adequate documentation in the multi disciplinary progress notes by the healthcare assistants and the enrolled nurse when she was on duty.

There has been no documentation of communication with [Ms B] by the registered nurses or the Clinical Nurse Manager who were on duty (reference — staff roster page 004190) while [Mrs A] was a client at Lester Heights Hospital. [Ms B] had voiced her concerns about her mother to several staff and only once was there any documentation about these concerns. This is in the Communication with Family Record Chart (reference page 00020). There is inadequate documentation by the registered nurses or Clinical Manager and I consider this to be a **severe** departure from acceptable standards.

CNM [Ms D] was on duty on all the days that [Mrs A] was resident at Radius Lester Heights, as the RN on duty on admission day there was no documentation by her. One could assume that she was made aware of the concerns expressed by [Ms B] about her mother's change of condition and yet there is no documentation in the nursing notes about this.

RN [Ms E] writes in her statement (reference pages 00239–00240) that she sought advice from CNM [Ms D] when [Ms B] requested a copy of the blood test results and that she was concerned about her mother's condition. I consider that this request should have prompted CNM [Ms D] to question RN [Ms E] about [Mrs A's] state of health and of [Ms B's] concerns.

CNM [Ms D] writes in her statement (reference pages 00248–00249) that she commenced [Mrs A] on a fluid balance chart so I assume that she was concerned about her fluid intake on day 2 since admission. In her defence the Registered Staff and any staff that [Ms B] expressed concerns to should have passed this on, firstly to the RN on duty, documented and communicated to the

CNM. All concerns expressed by families should be responded to. CNM [Ms D] would rely on the staff to communicate any concerns expressed by family members to her. I consider this to be a **moderate** departure from appropriate standards by CNM [Ms D]. However, I consider the lack of communication and documentation by the CNM and RNs overall is a **severe** departure from appropriate standards.

RN [Ms E] failed to document her conversations with [Ms B] also, I consider this to be a **moderate** departure from appropriate standards as she did seek permission from the CNM [Ms D] to give [Ms B] a copy of the blood test results.

(f) The adequacy of communication with [Dr J]

[Dr J] states in his letter (reference pages 00264–00266) that he was informed of [Mrs A's] admission to Radius Lester Heights Hospital 'at about 1630 on [Monday] 2009'.

He further states in his letter 'I was never informed of (a) her poor intake, and presumably very poor urine output, or (b) the fact that her daughter, [Ms B], was very upset and concerned regarding her mother's well-being.'

I consider the communication with [Dr J] to be inadequate and a **moderate** departure from acceptable standards. He was not contacted when [Ms B] requested to speak to him on the afternoon of [Thursday] (reference page 00240). He was obviously contactable as registered nurse [Ms E] did so on the afternoon of [Thursday] (reference page 00240 and 00265). The communication with [Dr J] was inadequate, firstly when he did his Initial Medical Assessment on [Tuesday] and not alerted to fact of her poor oral intake and the commencement of a fluid balance chart and later when [Ms B], daughter of [Mrs A], requested to speak to him about her concerns for her mother's wellbeing.

I consider the failure to alert [Dr J] to [Mrs A's] poor oral intake to be a **moderate** departure from an appropriate standard of care as a fluid balance chart had been commenced. RN [Ms D] commenced the fluid balance chart — if this had been documented RN [Ms F] could have passed this information on to [Dr J], however if RN [Ms F] had read the progress notes she could have alerted [Dr J] to the concerns documented by the care givers — who knew [Mrs A] was on a fluid balance chart as they were at least filling the form in as best they could.

I consider that the failure to alert [Dr J] to the fact that [Ms B] wanted to speak to him to be a **moderate** departure from appropriate standards as he was obviously contactable and [Mrs A] was a new 'unknown' resident.

(g) The adequacy of communication with [Ms B]

There are only five documented entries of communication with [Ms B].

Three of these are listed on the chart 'Communication with Family Record' (reference page 00020) and these are a written record of what [Ms B] had said to the staff.

The first on [Tuesday] — 'Daughter commented on how nice [Mrs A] looked today — tidy hair and co-ordinated clothes.'

The second on [Thursday] — '[Mrs A's] Daughter worried about [Mrs A] health' and '[Ms B], daughter removed engagement ring.'

The third on [Friday] — this was communication from [Ms B] after her mother had been admitted to [the public] Hospital.

There are two entries in the multidisciplinary progress notes of communication with [Ms B] (reference pages 00067 and 00068). The first dated [Wednesday] 'informed RN and her daughter about her eating' this is signed […] who is possibly [the healthcare assistant] (reference staff roster page 00419). The second dated [Thursday] (Reference page 00068) when enrolled nurse [Ms I] rang [Ms B] and left a message and later rang to inform that an ambulance had been called to transfer [Mrs A] to [the public] Hospital.

[Ms B] had voiced her concerns about her mother to staff and only once was there any documentation about these concerns. This is in the Communication with Family Record Chart (reference page 00020). There does not appear to have been any follow up to her concerns other than getting her a copy of the blood test results. I consider this to be a **moderate** departure from acceptable standards as there is no evidence of any follow up to these concerns.

[Ms B] had expressed her concerns to RN [Ms E] about the changes in her mother's health status and requested to speak to [Dr J] about these concerns (Reference page 00003). RN [Ms E] offered to take her details and pass them on to [Dr J]. RN [Ms E] states (Reference pages 00239–00240) that she did seek permission from CNM [Ms D] to give [Ms B] a copy of her mother's blood test results. I consider that RN [Ms E]'s failure to document this to be a **moderate** departure from appropriate standards.

I consider that CNM [Ms D] should have questioned the request for blood test results as this is not usual. This request alone should have prompted her to a) ask RN [Ms E] why [Ms B] had requested them and/or b) speak to [Ms B] — [Mrs A] had only been admitted the previous day. I consider that this is a **moderate** departure from appropriate standards.

3. Please comment on the adequacy of the policies and procedures in relation to:

(a) assessment and care planning (including admission procedures)

(With reference to Pre-entry & Admission to Radius Residential Care (pages 00118–00121), Assessment, Care Planning & Review Policy & Procedure

(pages 00122–00125) and consulting Health & Disability Sector standards, and Enrolled and Registered Nurses scope of practice and competencies.)

The admission, assessment and care planning policies cover all the requirements as per Health and Disability Sector Standards, however only states that the registered nurse responsible for admitting the client will complete the Initial Assessment/Care plan during the shift on which the client is admitted. As to who is responsible for completing the remainder of the assessment forms is not defined in the policies.

Within three weeks of admission there are many other assessments to be completed and the long term care plan implemented — these are the multidisciplinary team's assessments forms and there are only two that have the team member that is responsible for completing them identified.

With reference to page 00124 — subtitle 5.2 Care Planning — there should be reference to the RNs responsibilities re care plans. Enrolled nurses contribute to nursing assessments, care planning, implementation and evaluation of care but the registered nurse maintains overall responsibility for the plan of care. (Reference — Competencies for the Enrolled Nurse Scope of Practice www.nursingcouncil.org.nz.)

I consider these Policies and Procedures to be adequate.

(b) Handover on shifts

With reference to the Handover of Client Care between Duties Policy and Procedure (pages 001260–00127) there is a well documented policy/procedure that documents the responsibilities of all staff at the start and end of their shifts.

There is also a Daily Handover Sheet/Assistance Register that the RN reports from (reference page 00242) which should reflect the contents of the multi-disciplinary notes. I consider these Policies and Procedures to be adequate.

(c) Staff Orientation and Training

There is a policy/procedure form (reference pages 00128–00130) 'Orientation of Staff' which states that all new staff, contractors and volunteers participate in a planned orientation to the organization, their work and service. It outlines the processes of orientation and has a time span within which the orientation programme will take place. All new employees participate in a paid Orientation Programme within four weeks of commencing employment.

Reference pages (00131–00154) are an Orientation checklist and Self Learning Package for Caregivers — it is very detailed and covers a variety of topics related to their position. The caregiver is assigned a Preceptor/Buddy to explain or show them the items on the checklist. Once completed the checklist is placed on the employee's file. There is also a detailed self learning package with a resources list attached. There are also opportunities offered for ongoing education and the provision of ACE Core programme, Advanced programme

and Dementia programme. This is an excellent orientation training package for healthcare assistants to take advantage of and extend their knowledge.

Reference pages 00196–00218 is an Orientation checklist and Self Learning package for RNs — it is also very detailed and covers a variety of topics. The orientation and training policies and procedures are very adequate and cover the core requirements for staff.

Reference pages 00465–00480 — Clinical Manager Programme and Self Directed Learning Programme are a comprehensive pack for orientation and resource tool for Clinical Managers.

(d) Nutrition and Hydration

Reference pages 00157–00161 — Nutrition & Hydration Policy and Procedure is a comprehensive guideline to managing nutrition and hydration. It states on (page 00160) Mininutritional Assessment — 'On admission all clients are to have a mininutritional assessment completed by a registered nurse'. The Assessment, Care Planning & Review Policy and Procedure (reference page 00123) states that the requirement for this is within three weeks of admission. These procedures need to link in time frame requirements. This policy otherwise is very adequate and gives sound guidelines to follow.

4. Please comment on the adequacy of training provided to staff in relation to hydration and fluid balance sheets.

The Caregivers Orientation Checklist (Reference Pages 00131–00136) has several areas that require the item to be explained/demonstrated and signed by the inductor and inductee within the first three days of admission. These include: Assisting with client feeds, Care Plans, Fluid Balance Charts, Toileting and Clinical Assessment Guidelines for Caregivers.

Included in the Self Directed Learning Package for Caregivers (Reference pages 00137–00149) is a section on Hydration and Nutrition.

The questions in this section are: List 4 signs of dehydration; How many glasses of fluid do most clients require each day?; What would you do if you observed that your client is not drinking or eating?

The checklist and self directed learning package if taught well should alert the caregiver to their responsibilities regarding nutrition and hydration; what and who they should report to if the client was not drinking or eating sufficiently.

The RN Orientation checklist (Reference pages 00197–00002020) also has several areas of learning that must be demonstrated and signed off within the first three days of orientation which include: Assisting with Client Feeds, Care Plan Development, Toileting, Care Plans and Fluid Balance Charts.

The registered nurses Self Directed Learning Package also has a section on Hydration and Nutrition — the questions being: list 4 signs of dehydration;

How many glasses of fluid do most clients require each day?; Identify the parameters whereby a client is considered to have an unintentional weight loss?; When is a mini-nutritional assessment completed?; How often are clients routinely weighed?

The checklist and self-directed learning package should reinforce the education that registered nurses receive in training of nutrition and hydration needs and alert them to clients who are not eating and/or drinking adequately.

The incomplete fluid balance charts (reference pages 00063 and 00064) demonstrate that there has been inadequate education on the completing of these charts. In addition to this the fluid balance chart has errors — for example the Intake does not have a column for the time to be entered, the Output area has a column for Vol (volume) given.

The checklists and self directed learning packages list several staff that can be used as resources to complete the package.

There has been further training on Nutrition and Hydration following the events that led to this investigation (reference pages 00219–00234).

There is evidence in the multi-disciplinary notes that the caregivers were aware of their responsibility by their reporting of the low food/fluid intake of [Mrs A]. There was inadequate filling in and completion of the fluid balance chart and no documentation by any registered nurse that a) a fluid balance chart had been commenced or b) that any action was taken subsequent to the documented low input/output on [Mrs A's] fluid balance chart.

The training of the staff in these areas does not appear to be adequate from the evidence provided and I consider this to be a mild deviation from acceptable standards.

5. Please comment on the adequacy of systems or procedures in place to assist in the early detection of unstable or unwell patients.

There are robust admission procedures and forms for completion that give a baseline for reassessment and evaluation of care. (Reference pages 00122–00125 Assessment, Care Planning & Review Policy and procedure.) A Handover of Client Care between Duties Policy and Procedure (Reference pages 00126–00127) outlines the responsibilities of the care staff. Both the caregiver and RN Orientation Checklists (Reference pages 00131–00136 and 00197–00202) include education requirements about monitoring and assessment charts and practices that would enable adequate monitoring of the unstable or unwell client. There is also an On-Call Emergency Assistance Policy and Procedure (Reference pages 00462–00464) which has clear guidelines and instructions to follow when there is an unstable or unwell patient.

The Self Directed Learning packages attached to these two orientation booklets (reference pages 00137–00149 and 00203–00218) also include areas of learning that would assist the care staff to assist in the detection of unstable and unwell patients.

The Nutrition & Hydration Policy and Procedure (reference pages 00157–001610) reviewed in March 2009 has some clear guidelines and practices to follow with regards to a client's nutrition and hydration.

The Clinical Guidelines Index (reference page 00163) supplied lists 17 sets of guidelines available and the Nutrition & Hydration care Guide supplied (Reference pages 00164–00165) show a very systematic assessment and treatment plan to follow.

There is also reference material with attached self check questionnaire on Basic Assessment and Treatment Guidelines when dealing with Common Medical Conditions on the elderly. (Reference pages 00435–00461.) There is an adequate resource material for staff to refer to should their patient become unwell.

The Medical Officer to Radius Lester Heights hospital, [Dr J] has made a request 'that any hospital level patient who does not get admitted directly from a State hospital, please be assessed by their usual GP in the week preceding their admission to the Radius Private Hospital. In this way, if there has been a marked change or deterioration compared to prior reviews this would then hopefully be documented in their recent medical progress notes.' (Reference page 00266.)

There are adequate systems, procedures and resources available to assist in the early detection of unstable and unwell patients.

6. Please comment on the adequacy of systems or procedures in place to guide staff in the appropriate clinical management of unwell or unstable patients.

There are adequate systems and procedures in place to guide staff in the appropriate clinical management of unwell or unstable patients. (Reference — Question 5 statements.) Also refer to the Registered Nurses competencies and scope of practice (reference — www.nursingcouncil.org.nz).

7. In your view, was [Ms D] appropriately qualified and experienced for the position of Clinical Nurse Manager?

Reference letter Pages 00114–001160 — Part 4 of this letter notes that [Ms D] was originally employed as a Registered nurse [in 2007] and commenced the role of Clinical Manager on [in 2008]. There is no available record of her work history since her registration. There is a reference (Page 00253) of a staff member having worked with [Ms D] in an RN role for over four years.

The National Clinical and Quality Support Manager states in her letters (Reference page 00013 and 00114–001160) that [Ms D] was provided a full orientation.

A letter from a former employee of Lester Heights (Reference 00254–00255) suggests that [Ms D] received inadequate training for her new role as Clinical Nurse Manager because of an acute shortage of registered staff at Lester Heights.

[Ms D's] Staff Orientation Checklist — Registered Nurse (Reference pages 00197–00202) has only been signed by [Ms D] herself and only signed by the Facility manager on the cover page.

There was no evidence supplied of the completion of the Clinical Manager Programme — three day orientation package, self directed learning package and Feedback Form at three months (Reference pages 00465–00480).

There is a Clinical Managers Orientation Checklist (Reference pages 00179–00180) for [Ms D] that has been completed and signed by the inductees that are dated over a two day period. The subject content is quite extensive and there is no evidence in [Ms D's] Inservice records that she had any further inservices/education on management skills.

[Ms D's] Inservice Record (Reference pages 00181–00182) document attendance at in-services on nursing skills and compulsory education — for example — Fire, Manual Handling and Restraint.

[Ms D] had some years experience and was offered and accepted the position of Clinical Manager and this would indicate to me that she was appropriately qualified and experienced.

8. Please comment on the adequacy of the orientation, training and support offered to [Ms D] by Radius Residential Care Limited.

As commented on in section 7 of this report there is no supporting evidence in the documentation supplied that [Ms D] received the full orientation programme other than the letter from The National Clinical and Quality Support Manager (Reference page 00043 and pages 00114–00116) stating that she did receive full orientation. During [Ms D's] two day orientation at an Auckland site (Reference page 00115) she attended an in-service on Cardiac Assessment which would have reduced the orientation hours.

There is a Clinical Managers Orientation Checklist (Reference pages 00179–00180) signed off by inductees over a two day period — an extensive list of subjects to receive training in over a short time period.

The letter (reference page 000254–000255) by a previous Lester Heights employee comments that [Ms D] received 'no training programme, other than a two day visit to another Radius site'.

The several concerns documented by [the] National Clinical and Quality Support Manager (Reference pages 00045–00047) span several months and there appears to have been a lack of timely intervention by the Facility Manager (to whom [Ms D] was directly responsible to) to address any of these concerns.

A letter written by a previous Lester Heights employee (Reference pages 00254–00255) makes comment that there was a shortage of registered staff at Lester Heights when [Ms D] was appointed as Clinical Nurse Manager and that [Ms D] worked often in a registered nurses role rather than that of the Clinical Nurse Manager.

The in-service records for [Ms D] show no evidence of any further management training (Reference Pages 00181–00182).

In my opinion there has been inadequate orientation, training and support of [Ms D] in the role of Clinical Nurse Manager exacerbated by the fact that she was at times working a dual role as the Clinical Manager and the registered nurse. I consider this to be a **moderate** departure from acceptable standards.

9. Please comment on the adequacy of the changes made by Radius Residential Care Ltd as a result of this incident.

Several Policies and Procedures have been reviewed since the incident. (Reference Pages 00432–00433) of direct relevance are:

- On-Call/Emergency Assistance
- Nutrition & Hydration
- Orientation of Staff
- Handover of Client Care between Duties
- Assessment, Care Planning and Review
- Acuity & Clinical staffing Ratios
  - Pre-entry & admission to Radius Residential Care
  - Feeding a Client
  - Medical Service Policy

There has been in-service education on Nutrition and Hydration on 23/9/09 and 10/3/10 attended by 25 staff members. (Reference pages 00219–00220.)

The caregivers' and registered nurses' Orientation checklist and Self directed learning packages have been reviewed in April 2009.

Minutes of a registered nurses' meeting on 2/9/09 (Reference pages 00221–00224) had several items on the agenda following the complaint with documented action required regarding admissions, assessment, care planning and at risk residents. A handout on the Importance of Nutrition and Hydration in Residential Aged Care was provided and discussed (reference pages 00225–00234).

The response letter (Reference pages 00114–00116) from [the] National Clinical and Quality Support Manager indicates that 'clinical operational oversight at the facility has increased to ensure ongoing support and coaching of Registered Nurses to ensure appropriate standards of care are provided and maintained.'

There has also been a new appointment for Facility Manager.

Radius Residential Care Ltd is making efforts to put in place appropriate training and support to improve the standard of care being provided as a result of this incident.

I consider the changes made by Radius Lester Heights are adequate however I consider there could be further steps made to improve the service:

(a) That all new admissions have documentation in their multi-disciplinary progress notes by the registered nurse on all shifts for the first 48 hours of admission — this would ensure that they read the notes made by the healthcare assistants and provide baseline information for the completion of assessment forms that require completion to ensure an accurate Care Plan is formulated.

(b) Any follow-up/outcome to relatives concerns should be documented in the multi-disciplinary notes as the Family Contact Sheet does not include this information.

(c) Any concerns expressed by a relative as well as being documented needs to be brought to the attention of the registered nurse and Clinical Nurse Manager as soon as possible and responded to in a timely manner.

(d) That the preceptor or buddy of new staff receives ongoing training for that role to ensure they are teaching best practice and adhering to policies and procedures.

(e) That regular audits are carried out to ensure that Policies and Procedures are being adhered to.

[Ms D]

1. **Please comment generally on the standard of care provided to [Mrs A] by [Ms D] [over the four days].**

Referring to the staff roster for [Monday], [Ms D] was the only registered nurse on duty on the day shift that [Mrs A] was admitted to Lester Heights — [Monday].

She was listed on the roster as the CNM but as there were no other RNs rostered for that day shift I would assume that she would have fulfilled the RN

role. (Reference page 00419 Staff Roster.) This would have made her responsible for admitting [Mrs A].

The enrolled nurse on duty that day, [Ms I], could be directed by the registered nurse to assist with the admission procedures however the overall responsibility is the registered nurse as per Lester Heights Policy and Procedures.

[Ms D] states in her letter of response to the Commissioner 'I was never the registered nurse on duty during the time [Mrs A] was at Lester, I was the clinical manager and there was always another nurse on the floor responsible for patient care.' (Reference pages 00248–00249.) The enrolled nurse on duty that day, [Ms I], states in her response letter 'I do not remember the RNs that were on duty that day.' (Reference page 00237.)

The admission process was not carried out as per policy and procedure whoever the registered nurse on duty that day was. However, there was a registered nurse rostered on day shift for [Tuesday, Wednesday, Thursday]. A registered nurse was rostered on the afternoon shift on [Monday, Tuesday, Wednesday]. An enrolled nurse was rostered on [Thursday] afternoon and by Lester Heights Policy & Procedure for On-Call/Emergency Assistance there would have been a registered nurse on-call. (Reference pages 00162–00164.)

There was also a registered nurse on the roster for the nights of [Monday, Tuesday, Wednesday, Thursday]. (A Bureau nurse for [Wednesday, Thursday]) (Reference — staff roster — Page 000419.) [Ms D] was on the roster as the CNM during this time.

Although the required admission papers were not completed on [Monday] there was a registered nurse on duty (or in one case on-call) at all times. There are only two entries in [Mrs A's] multidisciplinary progress notes by any RN, one after transfer from Lester Heights. The RNs have to be accountable for their lack of documentation for the care provided and further instructions for ongoing care of [Mrs A]. There are faults on the standard of care provided by [Ms D] in that she did not ensure that the RNs were documenting in [Mrs A's] notes, therefore important information was not being passed on. I consider that failure to ensure the RNs were documenting in the progress notes a **moderate** departure from acceptable standards by [Ms D].

Also [Ms D] had been informed that [Ms B] was concerned about her mother's condition. She had been informed by a registered nurse when [Ms B] had requested a copy of her mother's blood test results. (Reference letter — Page 00240.) [Ms D] failed to follow-up on the concerns expressed by [Ms B] and discuss these with her when she had the opportunity. I consider this to be a **moderate** departure of acceptable standards by [Ms D].

2. Please comment on the level of oversight and supervision provided by [Ms D] to the nurses. In particular was it reasonable for [Ms D] to rely

on the nurses to report any concerns to her, or was a more proactive role required?

There has to be open communication between the nurses and their CNM. They should consult with the CNM if they have any concerns and/or want advice about their clients' cares. Communicating with families is also a very vital role of the CNM.

There is little documentation by the RNs of any concerns about [Mrs A] and no documented follow-up from the concerns documented by the healthcare assistants other than the commencement of a fluid balance chart. This however was not documented in her notes.

One staff member did report the concerns of [Ms B] to her and [Ms D] failed to follow-up on this. (Reference letter — Page 00240.)

A CNM is reliant on the nurses to report any concerns to them. The CNM would need to be more proactive if the nurses were failing to communicate and document.

It was reasonable for [Ms D] to rely on the nurses to report any concerns to her and to keep her informed.

[Ms D] should have been more pro-active in ensuring that the registered nurses were keeping her informed, communicating to the staff and documenting in the multi-disciplinary progress notes. This is a **moderate** departure from acceptable standards.

Other

Radius Lester Heights has a robust set of policies and procedures which all new staff is made aware of as part of the orientation checklist — it would be the individual staff member's responsibility to read and manager's responsibility to ensure they were adhered to.

The Facility Manager and the CNM have a responsibility to ensure that the staff member orientating new staff is trained for this role and carries out this task responsibly. They should also ensure that adequate time is given for the orientation process.

There has been a general failure in practice to adhere to the policies and procedures and the job descriptions by the Facility Manager, the CNM and the RNs of Radius Lester Heights. There has also been a lack of documentation in the multi-disciplinary progress notes by the RNs and follow up to ensure this was completed.

With relevance to this case are:

(a) Adherence to Policies and Procedures — Reference Facility Manager's and Clinical Manager's Job Descriptions 'Acts as a role model to care staff by personally maintaining excellent standards of clinical care and adhering to all Radius Policies and Procedures.' Reference Registered Nurse Job Description 'and complies with policies and procedures'.

The Policies and Procedures of relevance to this case have been:

1) Assessment, Care Planning and Review:

(Reference page 00123) The Initial Assessment/Care plan not completed within the timeframe and also not signed.

2) Handover of Client Care between Duties:

(Reference — Page 00126) 'All new treatments and incidents should be reported at handover.' The commencement of the fluid balance chart was not documented or handed over verbally to the staff.

The CNM and RNs had obviously NOT read the multi disciplinary progress notes where they would have been alerted to the caregivers concerns about [Mrs A's] poor fluid intake.

There is also documentation by a caregiver that the RN was informed of [Mrs A's] poor oral intake (Reference page 00067 — [Wednesday] am shift). I consider there has been a cumulative failure by all the RNs on duty to document any action following the documentation by the caregivers and consider it to be a **moderate** departure from appropriate standards.

3) Nutrition & Hydration:
(Reference Nutrition and Hydration Policy & Procedure — Pages 00157–00161.)

Although a fluid balance chart was commenced by the CNM the policy was not adhered to. There was no documentation in the notes, no verbal handover to staff about it and the Medical Officer was not informed. The form was incorrectly filled out and not totalled over 24 hours so can it be assumed that it was not looked at by the RNs or CNM (who had commenced the record?) thus ensuring it could be filled out correctly.

The RN on duty each shift should have been responsible to ensure that the form was filled out correctly and that the dehydration assessment was completed (reference page 00164). The CNM in commencing the fluid balance chart has failed to follow policy and procedure and the RNs have failed to act on the documentation by the caregivers in the multi disciplinary progress notes. The failure by [Ms D] to follow the Nutrition and Hydration Policy and Procedure I consider a **moderate** departure from acceptable standards.

4) Documentation:

There has been a consistent lack of documentation by the RNs during the time [Mrs A] was a client at Radius Lester Heights. The RN scope of practice and competencies and Radius Job Description clearly state the requirements of documentation. The CNM and Facility Manager have a responsibility to ensure that residents' needs are identified and documented and that clinical records are documented (Reference Job Descriptions of Facility Manager and Clinical Manager) therefore they have a requirement to oversee and ensure that the RN is adhering to the Job Descriptions and Policies and Procedures.

Radius Lester Heights has a responsibility to ensure that their staff are meeting the responsibilities as outlined in the Job Descriptions and adhering to their Policies and Procedures. The lack of documentation and follow up to ensure this was carried out is a **severe** departure from acceptable standards.

RNs have failed to fulfil the requirements of their job descriptions and would not meet some competencies of the scope of practice of an RN. (Reference Job Description — Registered Nurse and Scope of Practice and Competencies.) The areas of concern are:

a) Clinical Care Delivery where they have failed to monitor [Mrs A] and communicate their findings to the clinical team both written and verbally.

b) People Management where they have failed to provide supervision and coaching of caregivers and communicating the plan of care.

This is a **severe** departure from acceptable standards of care.

There has been an overall lack of oversight and communication at all levels of management at Radius Lester Heights as is evidenced by non adherence to job descriptions, documentation not completed and ongoing training of staff lacking — of note the fluid balance chart.

Addit — While I am hoping that the RNs have given appropriate nursing care to [Mrs A] their failure to document this and any discussions with [Ms B] fails to meet acceptable standards. This complaint could have been avoided had there been ongoing communication with [Ms B] and appropriate follow up to the caregivers documented concerns."

The following further advice was provided by Ms Brady on 1 February 2011:

"The Commissioner has asked for comments in the following areas:

[Ms E]

1. **Please advise whether your initial advice with regard to RN [Ms E] is changed in any way in light of RN [Ms E]'s response.**

My initial advice was that there was a general lack of documentation by the registered nurses on all shifts in [Mrs A's] multi-disciplinary progress notes.

For the three shifts that RN [Ms E] was on duty (Reference page 51 Staff Roster) she had not made any notes in the multi-disciplinary progress notes at all.

In her response to my initial advice (Reference pages 5–7) she writes 'I did not find and was not informed of any concerns of [Mrs A's] state of health …'

I am concerned that she had not read what was being written by the caregivers in these notes.

The lack of documentation and follow-up of the caregivers concerns I continue to consider being a **severe** departure from acceptable standards.

2. Please comment on the adequacy of the care provided by RN [Ms E] to [Mrs A].

As there is no documentation by RN [Ms E] I find it difficult to comment on her adequacy of care. In her letter of response (Reference Pages 5–7) she refers to changing [Mrs A's] tea with milk to a cup of black tea which indicates to me that she was aware of her likes and dislikes. This shows that she had read [Mrs A's] profile and was aware of her personal preferences and had used this knowledge in her provision of care to [Mrs A].

RN [Ms E] did speak to the Clinical Care Manager on the [Thursday afternoon] (Reference pages 00239–00240 of original supporting information) when [Ms B] requested to speak to the doctor and obtain copies of blood test results. This indicates that she has consulted with her senior — the CNM — and passed on [Ms B's] concerns about her mother's health. It would have then been prudent for RN [Ms E] to assess [Mrs A] and document her findings in the multi-disciplinary progress notes.

There has been inadequate documentation of care provided, follow-up of concerns documented by the caregivers and concerns expressed by [Ms B] in the multi-disciplinary progress notes.

I consider this to be a **moderate** departure from acceptable standards as RN [Ms E] has verbally passed on [Ms B's] concerns to the CNM.

3. Please comment on the adequacy of RN [Ms E]'s communication (with other staff and [Ms B]) with regard to [Mrs A] during the relevant period.

In RN [Ms E]'s response to my advice (Reference pages 5–7) she writes that she did pass on [Ms B's] concerns on [Thursday afternoon] to the Clinical Nurse Manager and had not documented this. She also writes that this was the first time she was aware that [Ms B] had concerns about her mother's state of health.

I would have expected the CNM to have followed up on this.

RN [Ms E] states she had offered to give her contact details to [Dr J] but [Ms B] had not commented on the offer. ([Ms B's] contact details should have been on her mother's file.)

RN [Ms E] also states in her response that she was not aware that a fluid balance chart had been commenced — there had been no documentation of this by the CNM who had commenced the record on [Tuesday] and the night staff also seemed unaware of it as well as they were not completing the total intake each night so I am concerned as to where this paperwork was located.

RN [Ms E] as well as the other RNs failed to communicate with each other either verbally or written and I believe are all responsible for the lack of communication with each other.

RN [Ms E] however did not appear to have read the multi-disciplinary progress notes that the caregivers had documented in or respond to their concerns. She was the RN on duty for 3 of the days that [Mrs A] was a resident at Radius Lester Heights.

There does appear to be a lack of communication between other staff, and RN [Ms E] had not read all the documentation concerning [Mrs A] and I consider this to be a **moderate** departure from acceptable standards.

4. Please comment on the adequacy of RN [Ms E]'s documentation during the relevant period with regard to the care provided to [Mrs A].

There has been no documentation by RN [Ms E] during the relevant period with regard to the care provided to [Mrs A] and taking into consideration [Mrs A's] co-morbidities and obvious deteriorating health I consider this to be a **moderate** departure from acceptable standards.

5. Do you have any additional comments to make on [Ms E]'s response?

It was evident that RN [Ms E] had read the initial profile of [Mrs A] as she had intervened when [Mrs A] was given tea with milk.

She also made comment in her response (Reference Pages 5–7) that [Mrs A] drank good amounts of water when taking her medications.

RN [Ms E] had also verbally passed on [Ms B's] concerns to the CNM and obtained permission to photocopy and give [Ms B] copies of blood test results.

RN [Ms E] was not the only registered nurse on duty during the relevant period of [Mrs A's] stay at Radius Leister Heights. I therefore consider that they should all take some responsibility for the lack of communication, documentation and responding to the reports written by the caregivers and those of [Ms B].

Radius Residential Care Ltd

1. Please advise whether your initial advice is changed in any way in light of Radius's response.

In light of the new information that I have reviewed my perspective on certain aspects of my advice differ from that which I originally gave.

In my previous report I commented that their policies, procedures and orientation packages were on the whole more than adequate in fact some of them excellent.

They have agreed in the most part to my comments and have reviewed and amended procedures accordingly.

As a result of their concerns they have extended disciplinary action to include the Facility Manager, [Ms C] who has subsequently resigned.

They have challenged my comment relating to orientation, training and support to [Ms D].

Since my initial report I have received additional material including [Ms D's] curriculum vitae.

Having now viewed the curriculum vitae of RN [Ms D] (Reference pages 81–87) she does appear to have had previous work experience that should have enabled her to meet the requirements of the role of Clinical Nurse Manager.

To fulfil this role [Ms D] would have needed to receive adequate support and ongoing training.

The Facility Manager has been challenged in her role through the commencement of disciplinary proceedings (Reference Pages 89–91).

I do not believe [Ms D] would have received adequate support and training from the Facility Manager [Ms C] as she herself was not meeting her role expectations in managing the facility to expected standards. I believe this may have impacted on RN [Ms D] obtaining adequate support from her superior, thereby affecting her performance in her role. There is still no evidence of [Ms D] attending any management training courses.

2. Do you have any additional comments to make on Radius's response?

Radius has put in more support and quality improvement initiatives to address the shortfalls in continuum care. (Reference pages 13–22.)

Radius now appears to be making every effort to ensure best practice.

[Ms D]

1. Please advise whether your initial advice is changed in any way in light of RN [Ms D's] response.

My initial advice has not changed in light of RN [Ms D's] response. Unless the roster was incorrect she was the RN on duty on the day that [Mrs A] was admitted and was responsible for the admission procedure as per Radius's policies and procedures. It was acceptable for her to direct the enrolled nurse on duty to complete some of the required documentation; however the overall responsibility was hers.

I also believe that family contact is very important and it would have been prudent of her to meet and talk to [Ms B] when the registered nurse advised her of her request for copies of her mother's blood test results and was asking to speak to the doctor.

2. Do you have any additional comments to make on RN [Ms D's] response?

I was interested by some of her statements, firstly — 'I was never informed of any major concerns about [Mrs A] until she was transferred to [hospital] and to this day I have never met her daughter.' As stated above I believe it would have been prudent of her to talk to [Ms B] when she was requesting copies of her mother's blood tests.

And secondly her statement 'that I am a scapegoat for Radius.' (Reference page 121) has me questioning whether the concerns expressed by Radius of the Facility Managers management of Lester Heights (Reference page 89) was impacting on her fulfilling her role as Clinical Nurse Manager."

The following further advice was provided by Ms Brady on 9 June 2011:

"I (Glenda Brady) have been asked to provide to … Investigator, Health and Disability Commission answers to the following questions.

1. If RN [Ms E] **did** inform [Ms D] of [Ms B's] concerns for [Mrs A's] declining health, how would you view the adequacy of the care provided by RN [Ms E]?

2. If RN [Ms E] **did not** inform [Ms D] of [Ms B's] concerns for [Mrs A's] declining health, how would you view the adequacy of the care provided by RN [Ms E]?

My response to question 1:

In her response [Ms E] stated that she had asked [Ms D's] permission to photocopy the blood test results of [Mrs A] for [Ms B] and that she had informed [Ms D] of the daughter's concerns about her mother's condition.

Why then did she not document this and [Ms B's] concerns and give guidelines to the staff for the ongoing care of [Mrs A]?

In my view the total lack of documentation by [Ms E] of any communication with [Ms D] and [Ms B] and any assessment and plan of care demonstrates inadequate care and responsibility towards meeting the needs of [Mrs A].

As I have written in my previous report, documentation is a record of care and is the domains of professional responsibility within the scope of practice of a registered nurse.

(The rosters that I have viewed have made me assume that it would have been [Ms D] who had commenced the Fluid Balance Chart so I would assume that she had some knowledge of [Mrs A's] low fluid intake from some source ? [Ms E]?)

My response to question 2:

It is my view that [Ms E] has provided inadequate care to [Mrs A] by failing to communicate to her CNM [Ms D], document any assessment and plan of care for [Mrs A] and follow up on the concerns expressed by [Ms B] and care giving staff.

She also did not inform [Mrs A's] doctor of the request by the daughter to speak to him about her concerns or of the changing health status of [Mrs A].

Glenda Brady."