Presbyterian Support Otago Incorporated (Ross Home and Hospital)

Ms C, Registered Nurse

Ms D, Registered Nurse

Ms F, Enrolled Nurse

A Report by the

Deputy Health and Disability Commissioner

(Case 10HDC01231)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A, aged 85, was a resident in Ross Home and Hospital's secure dementia unit (the Unit) for two months. Ross Home and Hospital is operated by Presbyterian Support Otago Incorporated.

2. During this time, Mr A fell frequently and was often agitated and aggressive. Few observations were taken during his stay at Ross Home and Hospital, and his care and management were not evaluated regularly.

3. On multiple occasions, staff used a lap-belt to restrain Mr A. Mr A's wife strongly objected to the use of restraint and communicated her wishes to staff several times. The procedure required by national *Health and Disability Services Standards*, and the Ross Home and Hospital *Restraint Policy*, was not followed. In particular, there was no discussion with Mr A's family about the use of restraint by appropriate health professionals, before restraint was initiated. Mr A's agitation increased after he was restrained.

4. Ross Home and Hospital was responsible for ensuring that Mr A received safe and appropriate care. The fact that multiple staff in the Unit used restraint but did not follow the appropriate procedure indicates systemic failures at Ross Home and Hospital. By failing to comply with the relevant *Health and Disability Services Standards*, Ross Home and Hospital breached Right 4(2) of the Code. Ross Home and Hospital also breached Right 4(1) for not having appropriate documentation and incident reporting systems in place in the Unit, for failing to ensure its staff communicated effectively with each other about Mr A's care (including about restraint), and for failing to ensure its staff evaluated his progress or responded appropriately to his falls and aggression.

5. Ms C, a registered nurse (RN), as the Unit Nurse Manager and Restraint Minimisation Co-ordinator at Ross Home and Hospital, was responsible for managing the Unit, educating staff in restraint minimisation, and ensuring the Ross Home and Hospital *Restraint Policy* was followed. RN C failed to complete and evaluate Mr A's support plan, or to manage and respond to Mr A's falls and aggression appropriately. RN C also failed to ensure that staff received appropriate training in restraint minimisation and failed to act appropriately in response to her staff restraining Mr A. Accordingly, she breached Right 4(1) of the Code.

6. RN D, an experienced RN, was responsible for restraining Mr A on at least two occasions without following the *Restraint Policy*. Consequently, RN D did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Complaint and investigation

7. The Commissioner received a complaint from Mrs A about the services provided to her husband, Mr A, by Ross Home and Hospital. The following issues were identified for investigation:

- *Whether the care provided to Mr A by Presbyterian Support Otago Incorporated (Ross Home and Hospital) between September 2010 and November 2010 was appropriate.*
- *Whether the care provided to Mr A by registered nurse RN C between September 2010 and November 2010 was appropriate.*
- *Whether the care provided to Mr A by registered nurse RN D between September 2010 and November 2010 was appropriate.*
- *Whether the care provided to Mr A by enrolled nurse EN F between September 2010 and November 2010 was appropriate.*

8. An investigation was commenced. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Complainant
Ms B	Consumer's daughter
Presbyterian Support Otago Incorporated (Ross Home and Hospital)	Provider
RN C	Unit Nurse Manager
RN D	Registered Nurse
RN E	Registered Nurse
EN F	Enrolled Nurse

10. Information was received from the following people on behalf of Presbyterian Support Otago Incorporated (Ross Home and Hospital):

Ms G	Manager, Ross Home and Hospital
Ms H	Operations Support Manager, Presbyterian Support Otago Incorporated
Mr I	Director of Services for Older People, Presbyterian Support Otago Incorporated
Ms J	Chief Executive Officer, Presbyterian Support Otago Incorporated

11. Information was also received from:

Ms K	Registered nurse

Ms L	Registered nurse and Acting Manager, Ross Home and Hospital

Also mentioned in this report:

Ms M	Nurse Practitioner

12. Independent nursing advice was obtained from registered nurse Sylvia Meijer, who has expertise in aged care. Her advice is attached as **Appendix A**.

Information gathered during investigation

13. This report focuses on the use of restraint on a resident in a hospital-level dementia unit. Mr A was restrained by a lap-belt on at least four occasions during the two months that he was a resident at Ross Home and Hospital (Ross Home).

Ross Home

14. Presbyterian Support Otago Incorporated is certified under the Health and Disability Services (Safety) Act 2001 to provide hospital and rest home services at Ross Home.[1] Ross Home provides hospital-level care for 84 residents, including secure psychogeriatric care for 24 residents. It also provides rest home care for a further 40 residents.

15. At the time of these events, Ross Home employed a sufficient number of nurses and carers to provide 4–4.5 hours of nursing/caring hours per resident per day. Ross Home has a registered nurse on duty in the general hospital at all times. At the time of these events, there was also either an RN or an enrolled nurse (EN) on duty in the Unit at all times.[2]

16. In 2010, the Unit Nurse Manager was RN C.[3] RN C was responsible for the day-to-day management of the Unit and for being a clinical role-model.[4] Her responsibilities included implementing effective orientation systems, collating accident/incident reports, supporting and mentoring staff, developing individualised support plans for each resident in the Unit, and ensuring staff in the Unit complied with Ross Home's policies and procedures.

[1] The name "Ross Home" is used in this report to refer to the rest home concerned, even though the provider is technically Presbyterian Support Otago Incorporated (the legal entity operating Ross Home).
[2] Ross Home advised HDC that it employed an EN rather than an RN owing to a nationwide shortage of RNs at the time.
[3] RN C was employed as the Unit Nurse Manager and, at all times, was rostered alongside another RN or EN.
[4] According to the Unit Nurse Manager's job description.

17. RN C was also the Restraint Minimisation Co-ordinator for Ross Home, which involved monitoring restraint use, and education of staff on the use and minimisation of restraint.

18. RN D was the sole RN in the Unit for some afternoon shifts. EN F was the only nurse in the Unit when she worked overnight.

Restraint

19. Restraint practices in rest homes are governed by the *New Zealand Standard 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (the *Restraint Standard*).

20. The *Restraint Standard* states that its main intent is: "to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices". The *Restraint Standard* expects restraint to be used as a "last resort" to maintain the safety of residents, staff and others, after all less restrictive interventions have been attempted and found to be inadequate.

21. Forms of restraint include the use of lap-belts, the raising of bedsides, and sedative medications.

22. If restraint is contemplated, the *Restraint Standard* requires the following process to be undertaken:

1. A process for determining approval of all types of restraint used.
2. An assessment of consumers in relation to the use of restraint, which includes informing the consumer and/or the consumer's family and seeking their input where practicable.
3. Safe restraint use, including continuous monitoring, regular reviews, and detailed documentation of each episode of restraint.
4. Evaluation of all episodes of restraint, in collaboration with the consumer, and their family when appropriate.
5. Comprehensive reviews of restraint practice at an organisational level, to determine (among other things) the extent of restraint use and compliance with policies and procedures.

23. The *Restraint Standard* required Ross Home to provide ongoing education to its staff on the appropriate use of restraint. It also required Ross Home to develop clear policies and procedures to guide its staff in the implementation of the *Restraint Standard*. Accordingly, at the time of these events, Ross Home had a *Restraint Minimisation and Safe Practice (Including Enablers) Policy* (the *Restraint Policy*).

24. Ross Home's *Restraint Policy* required the following:

1. An approval process, involving discussions with the resident, his or her family, internal and external health professionals, and multi-disciplinary specialist input. It also requires review of new cases of restraint at both "home level" and the level of aged care residential services collectively.

2. An assessment process to consider key indicators for the use of restraint, including the presence of dementia and a history of falls. The assessment process should also consider whether there are underlying causes for the resident's behaviour or condition that requires restraint. The resident and/or his or her family are to be involved in the assessment process, and all relevant possible alternatives must be considered and/or tried.

3. Documentation of restraint use, including the reasons for the use of restraint, contributing factors or triggers, completed medical and falls risk assessments, alternatives that have been considered or tried, location and duration of restraint, frequency of monitoring during restraint, type of restraint, and risks associated with the use of restraint. The decision to approve restraint must be reflected in the resident's lifestyle notes, and acute episodes must be documented on an incident form.

4. Processes to reduce the risks associated with restraint, including education and training in restraint, maintenance of a restraint register, appropriate documentation and monitoring of restraint, and ensuring it is used only as a last resort.

5. Processes to evaluate restraint use, requiring all episodes of restraint to be evaluated.

6. Mechanisms for the quality review of the use of restraint, including internal twice-annual audits and reporting to the Restraint Minimisation and Safe Practice Committee.

Mr A

25. In 2010, Mr A had advanced dementia. In 2004, he had given his wife, Mrs A, enduring power of attorney in relation to his personal care and welfare.[5]

26. In July 2010, Mr A (then aged 84) was admitted to a public hospital owing to restless wandering behaviour in the evenings, and poor sleep. He had been living at home with his wife and daughter. Mr A remained in hospital until September 2010 for a period of assessment and to review his medication.

27. On 19 August 2010, while Mr A was still in hospital, a needs assessment was undertaken. The assessment concluded that Mr A required a very high level of assistance and care from nursing staff with specialist dementia knowledge. It was also necessary to manage his mobility needs given his high risk of falling, his high level of agitation and restlessness, and his fearfulness and aggression. The needs assessment records that Mrs A wished to care for Mr A at home, but had reluctantly accepted the multidisciplinary team's advice that it was no longer a safe and manageable option for one person to provide for Mr A's care needs.

[5] A form of enduring power of attorney under the Protection of Personal and Property Rights Act 1988. At the time of these events, Mr A had not been certified as mentally incapacitated by a medical practitioner in the form required by sections 98(3) and 99D of the Protection of Personal and Property Rights Act 1988.

28. During Mr A's stay at hospital, several medications were trialled to manage his day–night reversal,[6] and balance sedation with management of aggression. On discharge, Mr A's regular medications included quetiapine[7] and quinapril.[8]

29. On 7 September 2010, Mr A was discharged from hospital[9] and admitted to the Unit at Ross Home the same day. Mr A was a resident at Ross Home until he returned home on 9 November 2010.

Initial assessment and long-term support plan

30. The *Age Related Residential Care Services Agreement*[10] requires each resident to be assessed on admission in order to establish a care plan, which must then be developed, documented and evaluated within three weeks of admission.[11] That practice was in place at Ross Home when Mr A was admitted.

31. Prior to Mr A's admission, his family completed a detailed personal history, which included a request that no restraints be used in attempts to re-introduce him to his bed. This documentation was placed on Mr A's file on his admission to Ross Home.

32. A *Resident Initial Nursing Assessment* was partially completed for Mr A and signed by RN E and Mrs A on 7 September 2010. Under the heading "Restraint", RN E recorded: "[Mrs A] is happy for bedsides to be up at night." Mrs A told HDC that she had made it clear to RN E on admission that under no circumstances did she want Mr A to be restrained.

33. Falls risk and pain assessments were completed for Mr A on admission, and Mr A was assessed as being at medium risk of falls. Ross Home's visiting general practitioner also assessed Mr A on admission. The following day, a continence assessment, pressure risk assessment and resident transfer plan were completed by Ross Home staff and, in the following weeks, assessments were completed by a dietitian, occupational therapist and physiotherapist. A social history assessment was also completed.

34. No baseline observations (blood pressure, temperature, pulse, blood sugar level) were recorded on Mr A's admission. On 11 September 2010, Mr A's blood pressure, temperature, pulse and respiration rate were recorded, and were all normal except his blood pressure (low at 95/50mmHg). On 4 November 2010, Mr A's temperature was recorded as normal. No other observations were recorded throughout Mr A's stay at Ross Home.

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[6] Mr A slept during the day and was awake during the night.
[7] An antipsychotic, sometimes used to treat dementia and its symptoms.
[8] Quinapril is used to treat high blood pressure and symptoms of congestive heart failure. It is also used for renal protection in patients with diabetes who do not necessarily have high blood pressure or congestive heart failure, such as Mr A.
[9] Ross Home noted that the discharge summary indicates that Mr A was restrained during his stay there.
[10] This Agreement is between the service provider (Presbyterian Support Otago Incorporated) and the funding DHB.
[11] Clauses D16.2(b) and D16.3(c) of the Aged Related Residential Care Services Agreement.

35. Ross Home provided HDC with a copy of Mr A's Lifestyle Support Plan (the support plan). The designated spaces for dates and signatures for each section are blank.[12] The support plan included the following headings: issues of consent (including restraint), rest and sleep, elimination, skin integrity, personal care, nutritional status, mobility, and communication. The support plan noted Mr A as being at high risk of falls, and indicates that he had a tendency to wander and required redirection during the day and night. It noted that he was sleeping for no more than one to two hours at a time on a reclining chair in the lounge rather than in his bed, and had not responded to medication trials. In light of his falls risk, interventions listed on the support plan included offering Mr A his walking frame, redirecting him, using night lights, keeping his bed at the lowest level and ensuring he wore shoes with a low heel and good support.

36. RN C told HDC that she completed Mr A's support plan in late September or early October 2010. In contrast, Acting Manager Ms L said that on 28 October, she could not find a support plan for Mr A, but that an undated plan "appeared" on Mr A's file on 30 October, almost eight weeks after Mr A's admission.

37. EN F and RN D do not recall reading Mr A's support plan. RN E said that she does not recall working with resident support plans when RN C was the Unit Nurse Manager. RN C said that the RNs did not read the support plans, and that the RNs had told her they did not have sufficient time to do so.

38. The support plan records that Mr A was not to be restrained, but staff were to contact his family in the event of agitation and aggression. It notes "de-escalation"[13] under "Interventions", but no specific strategies are listed. There was no further documentation relating to restraint on Mr A's file.

39. There is no evidence that the support plan was ever reviewed or evaluated. However, there is evidence that Mr A's medication was reviewed regularly, and altered to address his behaviour and improve his sleeping patterns.

Mr A's behaviour and care

40. It is evident from Mr A's records that his behaviour and care were difficult to manage. His records show 13 instances of aggression towards staff or other residents during his short stay at Ross Home. There are also numerous documented instances of unsettled and agitated behaviour.

41. In addition, Mr A fell at least ten times in the space of one month, and two of these falls resulted in injuries. EN F told HDC that Mr A "was an extreme falls risk, falling most nights". RN C told HDC that from his admission, there was increasing concern from the afternoon and evening RNs about Mr A's unsettled nights. She stated: "He did not wish to sleep in his bed and he slept most of the time in his chair or wandering through the night."

[12] There is no designated space for a family member to sign the support plan.
[13] The Ross Home restraint minimisation training information defines de-escalation as "a mixture of one or more techniques to calm a situation or behaviour in order to avoid the use of restraint".

42. Mrs A advised HDC that she told Ross Home on numerous occasions that staff could contact her at any time, day or night, if her husband became difficult to manage, and she would come in to Ross Home to assist staff with her husband.

Restraint — 7 September 2010

43. According to RN D, there was no restriction on Mr A being restrained for the initial two weeks following his admission to Ross Home. Ross Home advised that RN D was "completely mistaken in her assertion" and said that this was not and has never been the case.

44. At 7.30pm on 7 September 2010, Mr A was restrained in a chair by a lap-belt. RN D documented in Mr A's lifestyle notes: "Pt [patient] restrained in chair at 1930 — Calling out and trying to walk, very unsteady, won't use his frame." RN D also recorded that an incident report was completed, but Ross Home was unable to produce a copy of this report for HDC.

45. EN F was on duty overnight on 7 September and recorded the following in Mr A's lifestyle notes:

> "[Mr A] has been in chair all night changed [two times] as [he] had shredded his P.J and [two] pads. [A]ggressive first round while changing standing hoist used. Second change was managed well without hoist. [Mr A] stayed in lounge and slept at times."

46. The following day, a visiting Nurse Practitioner, Ms M, documented that Mr A's first night did not go well and that staff restrained him in a chair for the night.

47. Mr A's family were not informed that Mr A was restrained overnight on 7 September 2010.

Restraint — 9 September 2010

48. Mrs A recalls that when she visited Mr A on 9 September 2010, she found him reclining in a chair, restrained by a lap-belt and trying to get up. Mrs A recalls asking the registered nurse on duty about the use of restraint and was assured that restraining residents is "against the law".

49. There is no documentation relating to the use of restraint on Mr A on 9 September 2010.

Discussion with Mrs A about restraint

50. RN C was on leave when Mr A was admitted to Ross Home. She returned to work on 10 September 2010. She said that on returning from holiday she would read all resident notes for the period she was away. However, she did not see RN D's note of 7 September or Ms M's note of 8 September relating to restraining Mr A.

51. Mrs A told HDC that she expressed concern to RN C, on the day she returned from leave, about Mr A being restrained.

52. RN C recalls that, on 10 September, Mrs A asked her about restraint. RN C stated that she explained to Mrs A that if a resident were hurting himself or others, or disturbing the therapeutic environment, the staff would use restraint but, in the Unit, restraint usually involved the use of bedsides. RN C recalls Mrs A telling her that Mr A became more agitated and aggressive when he was restrained. RN C also recalls that Mrs A clearly advised her not to apply any form of restraint to Mr A. This discussion is not documented. RN C told HDC that she was aware of the distress previous applications of restraint had caused to Mr A's family, and that they would prefer him to fall than be restrained.

Restraint — 23 September 2010

53. In the evening of 23 September 2010, RN E used a lap-belt to restrain Mr A. RN E documented the following in Mr A's lifestyle notes:

> "[Mr A] was put to bed in a chair in the lounge. He would not stay in it and got up several times. I decided to use a restraint belt as this was in use on admission to [the Unit] and both his wife and daughter were in agreement about its use. Once unable to get up [Mr A] quickly fell asleep."

54. RN E told HDC that she was aware that the *Restraint Policy* requires a discussion with the resident's family and said that the Unit Nurse Manager would have had this discussion.

55. There is no documentation relating to the duration or monitoring of the use of restraint on 23 September 2010, and Mr A's family was not informed that restraint was used.

56. On 26 September 2010, Mrs A telephoned Ross Home to report a bruise on Mr A's groin. Staff recorded bruising around Mr A's groin area on 26 September, 27 September and 2 October. Mrs A recalls being informed on 27 September that the bruise had spread to his abdomen. Ross Home's visiting GP reviewed Mr A on 29 September and recorded some bruising on Mr A's groin.[14] Mrs A said that the bruising lasted for three weeks.

Restraint — 7 October 2010

57. RN D was on duty until 11.15pm on 7 October 2010, and EN F was on duty overnight. EN F recorded in Mr A's lifestyle notes that he was unsettled all night, sleeping at intervals in his chair. Although there is no mention of restraint in the lifestyle notes, at 8.30am on 8 October, RN C and another RN found Mr A sitting on a chair with a lap-belt restraint on.

58. In response to my provisional decision, Ross Home stated that when staff were interviewed about this incident, there was disparity between their account of events. It stated that there is therefore doubt about whether the restraint on 8 October actually occurred.

[14] The GP presumed that the bruising was related to restraint, but Ross Home stated that the bruising may have been caused by the use of a full body hoist to lift Mr A from the ground when he had fallen.

59. However, RN C completed an incident report, which noted that the restraint was not mentioned at handover but stated that RN D had restrained Mr A to prevent him from falling because she was very busy. It further stated that no assessment form, consent form or monitoring form was available.

60. RN C stated that she gave a copy of the incident report to Ross Home Manager Ms G, who denies receiving this. The incident report was not provided to HDC with Mr A's file, but was found by Ms G and another RN in the Unit Nurse Manager's office on 9 December 2010. RN C told HDC that she spoke with various staff members about the incident and, on 10 October, advised Mrs A of the incident.

61. According to Ross Home, RN D advised that a caregiver restrained Mr A at approximately 10pm. However, when questioned by HDC, RN D said that she could not recall the events and denies ever restraining or directing the restraint of Mr A.

62. RN C said she responded to this incident of restraint by instructing the staff not to restrain Mr A. Under "corrective actions" on the incident report, RN C documented:

> "This [issue] of concern has been addressed during handover at AM and PM shift. Written reminder in communication book and support plan."

63. RN C's entry in the staff communication book relating to this incident was on 13 October 2010:

> "Attention NB — [Mr A] — is not on any type of restraint — family asked not to place lapbelt in the event of agitation — please contact family any time and discuss behaviour that causes concern — thanks — [RN C]"

64. RN C told HDC that she also wrote a similar instruction in the front of Mr A's file, and on a piece of paper pinned to one of the office whiteboards. Mrs A recalls that RN C documented on the staff whiteboard and Mr A's file "something along the lines of 'If any behavioural problems please contact wife, no restraint'".

Restraint — 26 October 2010

65. On the night of 26 October 2010, EN F restrained Mr A with a lap-belt. EN F and a caregiver were on duty overnight. EN F did not consult an RN before restraining Mr A. She told HDC that staff could call the RN in another unit if they had a problem, but said that the RN would probably have advised her to restrain Mr A. EN F documented in the lifestyle notes:

> "Nocte — [Mr A] slept well until 1.50 up and walking round calling out coming into hall way trying to go into rooms, aggressive when tried to settle him back in chair, toileted and given quetapine and restrained in chair until asleep restraint remove[d], settled night after that."

66. EN F told HDC that the lap-belt was used for 30 minutes. She did not document the duration of the restraint. RN C, who came on duty at 8am, wrote in the margin of the lifestyle notes that the lap-belt was released after one hour.

67. EN F told HDC that she was unaware that Mr A's family was opposed to the use of restraint. She said that, on this occasion, Mr A had been agitated and aggressive, pulling chairs and going into other residents' rooms. EN F said that she had tried everything she could to settle him, but restraint needed to be used for his own safety to prevent him from breaking glass or breaking a hip. She believed she was doing the right thing for Mr A, and advised that the RNs told her she could restrain Mr A if necessary.

68. EN F told HDC that she discussed the 26 October use of restraint with Acting Manager Ms L, who directed her to complete an incident form. EN F said she gave this to RN C at 7am on 27 October 2010. RN C said she did not receive that incident form but that EN F verbally informed her of the use of restraint. Ross Home was unable to produce a copy of the incident report for HDC.

69. Ms L said that on 27 October she saw an undated note on the office whiteboard stating:

> "Attention: All Staff
>
> [Mr A] is not on any type of restraint. Please contact his wife or daughter in the event of behaviour that causes concern anytime [aggression, intrusive]. Thanks [RN C]."[15]

70. RN C contacted Mrs A on 28 October to advise her that Mr A had been restrained again because he had disturbed the therapeutic environment by waking up other residents and banging on doors. RN C stated that she also reported the restraint to Ms L on 28 October.

71. On 30 October 2010, RN C documented in the Unit RN communication book (kept in the treatment room):

> "[Ms F] — [Mr A] is not on any type of restraint, if he become[s] personally intrusive to other peoples room, or any agitation or aggression, consult the RN on duty in [another Unit], if possible offer food or hot drinks, let him wander as long as hip protection pants is in place — after all this interventions failed, please ring [Mrs A] anytime. Thanks."

Documentation

72. The Ross Home's Resident Falls and Risk Assessment policy (*Falls Policy*) requires documentation of all falls in the resident's lifestyle notes, and the completion of an incident report. Ross Home provided HDC with eight incident forms completed as a result of Mr A suffering a fall. However, Mr A's lifestyle notes show that he fell 11 times. Accordingly, there was no corresponding incident report on Mr A's file in relation to three of these falls.

[15] It is unclear when this note was written.

73. The *Falls Policy* also requires a falls risk management plan to be developed according to the findings of the falls risk assessment. There is no such plan on Mr A's file.

74. The Ross Home Resident/Client Incident, Accident and Near Miss Reporting policy (the *Incident Reporting Policy*) requires that challenging behaviour (among other things) is recorded on an incident report. The lifestyle notes show that Mr A was aggressive on 13 occasions, but HDC has been provided with only six incident reports in relation to his aggressive behaviour (two of which relate to the same incident). Accordingly, there was no corresponding incident report on Mr A's file in relation to eight incidents of aggressive behaviour.

75. Four of the incidents that are documented in the lifestyle notes refer to completed incident reports, copies of which Ross Home was unable to produce for HDC. When asked why these reports were not provided, Ross Home stated that "there was a large quantity of [incident reports] found buried in a [drawer] and while we cannot evidence such, it is likely that others were 'vanished' as well as hidden. We have no reason to disbelieve staff when they say that [incident reports] have been completed, however we cannot find [the incident reports HDC requested]."

76. RN C was responsible for incident reporting and follow-up actions. She stated that she read all incident reports, discussed them with staff, and then, at the end of the month, reported them to the head office and placed the reports on the respective residents' files. According to RN D, RN C discussed incident reports with staff on duty in the morning. However, RN Ms K and RN D said that they did not see incident reports again once the reports were given to RN C, and that the reports were not placed on the residents' files.

77. There is no evidence that any observations were taken following Mr A's falls. RN D noted that equipment for routine observations was not readily available, for example, thermometers were stored in locked cupboards which the RNs could not access.

78. Mr A was seen by Nurse Practitioner Ms M seven times, and by a GP 11 times. Key information from assessments by Ms M and the GP was not reflected in Mr A's support plan. Furthermore, Ms M's notes were not filed consistently by staff. Ms M told HDC that her notes were kept "all over": sometimes with medical notes, sometimes in the nursing section, and sometimes filed randomly.

Staff communication

79. There were a number of written communication methods used by Unit staff: a staff communication book, an RN communication book kept in the treatment room, a GP communication book, and two office whiteboards.

80. Manager Ms G advised HDC that she was unaware of an RN communication book until she found one in the Unit treatment room on 17 February 2012. She said that no other unit at Ross Home had a separate RN communication book.

81. RN C told HDC that Mrs A's wishes regarding restraint were recorded in the communication books and on the Unit whiteboard, which she said contained all

relevant resident instructions and details. She later stated that Mrs A's wishes were also written in Mr A's support plan.

82. EN F recalls seeing the whiteboard instruction about restraint "some time" after she restrained Mr A on 27 October 2010.

83. RN D had no memory of any instruction not to restrain Mr A. She advised that most communication was passed around by caregivers, who seemed to know what was going on more than anyone else, and at handover in the mornings.

84. Ross Home advised that the correct place for the instruction about restraint was on Mr A's support plan, and that RN C should have ensured all staff received the instruction about restraint by way of a written handover at the beginning of each shift.

85. RN E said that she mostly worked on her own, and that RN C was not particularly communicative.

Staff training in restraint minimisation

86. Ross Home's *Restraint Policy* provides for new staff to receive training prior to using restraints or enablers. The generic orientation checklist includes a section that requires a meeting with the Restraint Minimisation Co-ordinator to be signed off within two weeks. Ross Home advised that all staff were required to attend annual training in restraint minimisation. This one-hour training session covered Ross Home's philosophy, de-escalation techniques, the risks associated with restraint and reducing these risks, alternatives to restraint, Ross Home's assessment process, documentation, and evaluation of restraint use.

87. RN D has been an RN since 1961. She had already been working in another unit at Ross Home for two months when she started working in the Unit in 2009. She said she received no formal orientation to Ross Home, but followed around another nurse who showed her the ward and the rooms when she started in one of the other units, and similarly when she started in the Unit. RN D said that her orientation did not include restraint minimisation. She had one training session in restraint minimisation but remembers being taught "very little". She was not aware that restraint required monitoring and documentation. RN D advised that RN C provided her with "poor" support, did not directly supervise her work, and that she (RN D) relied on what the caregivers told her. Ross Home did not provide HDC with RN D's orientation record, and advised that it could not be found.

88. EN F was registered as an enrolled nurse in 1989. She started working at Ross Home on 16 March 2010 but was on leave from 28 March 2010 until 27 July 2010. Ross Home advised that she was not fully orientated to the Unit, and had not attended restraint minimisation training. Prior to this complaint being made, EN F did not know who the Restraint Minimisation Co-ordinator at Ross Home was, and she had not read the *Restraint Policy*. The completion of her orientation was overlooked when she returned to work from leave. Ross Home advised that EN F did not have an orientation record.

89. Despite commencing employment as an RN on 6 April 2010, RN E's orientation record indicated that she did not meet with the Restraint Minimisation Co-ordinator within two weeks of employment (as required by the orientation checklist) and she has no memory of meeting with the Restraint Minimisation Co-ordinator during the time RN C held that position. The first time RN E attended in-service restraint minimisation training was on 25 November 2010 (ie, after Mr A had left Ross Home).

Unit Nurse Manager

90. RN C was employed at Ross Home from October 2006, having graduated as a registered nurse in August 2006. There is no documented orientation for RN C from the commencement of her employment in October 2006.

91. RN C was promoted to Nurse Manager of the Unit in December 2006. Manager Ms G told HDC that RN C did not have prior management experience at the time she was promoted, but was appointed as she "interviewed well, was thirsty for knowledge and wanted the position".

92. RN C told HDC that she had had no prior management experience or dementia experience and received no dementia training when she started in the Unit. Following her appointment as Unit Nurse Manager, a "new appointee checklist" noted that no buddy day was required as RN C was already working as an RN. RN C would have received a minimum of five days' orientation with another RN when she first started at Ross Home.

93. According to Ross Home, RN C's orientation to the position of Unit Nurse Manager consisted of spending time with the other Ross Home Unit nurse managers, Ms G and other senior staff. There is no record of this. RN C said that the outgoing Unit Manager orientated RN C to the Unit for two hours on her first morning.

94. As the Restraint Minimisation Co-ordinator, RN C attended a one-hour restraint minimisation training session in 2007 and met with the then Restraint Co-ordinator for a full day's training. RN C attended 21 Restraint Minimisation and Safe Practice Co-ordinators' committee meetings between 2007 and 2010, and provided training in restraint minimisation to staff on five occasions.

95. Ms G stated that RN C needed coaching in documentation and had little understanding of near miss and incident reporting. Ross Home provided evidence of RN C's attendance at numerous education events, including a Dementia Today workshop in September 2009 and an Alzheimer's conference in May 2010. Supervision for RN C between August 2008 and January 2009 was paid for by Ross Home, but was ceased in January 2009 by RN C against the recommendation of Ms G. RN C attended a team leader workshop on 18 September 2007. Goals for RN C for 2007–2008, as recorded in RN C's personnel file, included "continue to explore other management training", but it is not clear whether that occurred.

96. RN C said she felt unsupported by management when addressing staff education, communication within the unit and workload. In response to my provisional decision, she said that a major contributing factor to the shortcomings in her practice was her

promotion to a position of management without adequate management experience or an appropriate level of monitoring. However, RN C has not provided HDC with any evidence of requests for additional support. She advised HDC that she "may not have been adequately equipped to effectively manage the roles [and] should have addressed this further…"

97. RN C's performance appraisal from December 2007 to December 2009 noted that:

> "more meetings with Families is needed. The past year has been a difficult one for [RN C]…
>
> Incident forms need more timely completion on the back part of the form…
>
> She has some occasions when communicating with some staff is difficult. This has improved greatly in past 12 months…
>
> [RN C] has come into the position without management experience…
>
> [RN C's] style of leadership is by leading from the front but I believe she should allow the RNs more autonomy at GP visits and clinical reviews…
>
> [RN C] has undertaken no less than 40 attendances at workshops and seminars relevant to her work…
>
> [with respect to negotiation and conflict resolution] This is a challenging area I believe, for [RN C]…
>
> [with respect to audits] [RN C] does not always complete on time but [does] get there eventually…"

98. In response to my provisional decision, RN C accepted that there were shortcomings in her practice, including as a manager, and acknowledged that Mr A did not at all times receive the level of care and consideration to which he was entitled. She stated that she was undertaking further training and education which had improved her communication skills.

Subsequent action by Ross Home

99. Ross Home acknowledged to HDC that Mr A was restrained on at least two occasions, that documentation was inadequate, and that staff did not follow the *Restraint Policy*. Ross Home also acknowledged that Mr A's support plan was not fully completed or in place within the required timeframe.

100. Ross Home wrote to Mrs A on 20 December 2010, stating:

> "When [Mr A] was admitted to [the Unit], a full discussion should have taken place about matters relating to restraint. In cases where the safety of a resident or someone else [cannot] be maintained despite the implementation of all other interventions, it is usual to have in place a restraint protocol such that restraint can be used to ensure the safety of everyone."

101. In response to my provisional decision, Ross Home submitted that the failures that occurred at Ross Home during Mr A's stay were isolated to the Unit. Ross Home advised that the facility had been reviewed in three external audits since December 2010, including a review of the *Restraint Policy*, and that the audit results showed "that excellent care was being provided in the other four units" at Ross Home. Ross Home advised that there are now different coloured forms and labels to assist with identifying the different types of restraint.

102. Ross Home advised HDC of the following corrective actions that have taken place in the Unit:

- the appointment of a new Unit Nurse Manager;
- a review of RN staffing levels;
- full clinical multidisciplinary reviews with family involvement for all residents (including restraint review);
- a review of all support plans, including the restraint section;
- the addition of a family communication page to residents' files;
- coaching regarding correct admission procedures;
- strengthening of the process for ensuring all staff receive full orientation;
- regular monitoring of documentation;
- auditing by the Unit Nurse Manager of two files each month to ensure compliance with policy and procedure;
- the purchase of electronic wrist band blood pressure monitors;
- training on restraint minimisation four times per year. Staff are required to attend at least one per year;
- the implementation of a monthly audit tool for assessment, intervention and evaluation/review and its documentation (copy of audit tool provided);
- the documentation of interventions/specific de-escalation strategies as part of residents' support plans;
- families now sign support plans to show they have read and understood them;
- work is being done on acute restraint procedures;
- in-service training on restraint for new staff is held on the third Monday of each month;
- an updated template for the section of support plans relating to restraint was supplied, prompting staff to consider discussion with family, assessment and review, monitoring, and documentation.

Ross Home also advised that training sessions had been held as follows:

- Restraint minimisation training (25 November and 2 December 2010)[16]
- Incident and accident reporting in-service training (9 February 2011)
- Nursing/caring documentation in-service training (16 February 2011)
- RN and EN documentation in-service training (8 June 2011)
- Restraint (September 2011)

[16] Ross Home provided evidence including the attendance list and the staff training package.

103. Since these events, EN F has completed a course in restraint minimisation at Ross Home and reports having taken steps to improve her documentation and awareness of Ross Home policies. RN E told HDC she has become more involved in the support plans for residents, and more aware of the need to consider assessment, monitoring and evaluation of restraint when the need for this was identified. RN D has retired since these events occurred.

104. RN C told HDC that she has accepted that her management skills and documentation required development and that she is undertaking further nursing training.

Relevant standards

105. **Health and Disability Services (Restraint Minimisation and Safe Practice) Standards**[17]

Standards New Zealand has produced standards for the Health and Disability sector.[18] The foreword to the *Restraint Standard* states:

> "The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.
>
> Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices and training should be firmly grounded in this context."

The Standards are:

Restraint minimisation

Standard 1	Services demonstrate that the use of restraint is actively minimised.

[17] NZS 8134.2:2008.

[18] Standards New Zealand explains standards on its website as follows: "Standards are agreed specifications for products, processes, services, or performance. New Zealand Standards are developed by expert committees using a consensus-based process that facilitates public input. New Zealand Standards are used by a diverse range of organisations to enhance their products and services, improve safety and quality, meet industry best practice, and support trade into existing and new markets."

Safe restraint practice

Standard 2.1	Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint and ongoing education on restraint use and this process is made known to service providers and others.
Standard 2.2	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.
Standard 2.3	Services use restraint safely.
Standard 2.4	Services evaluate all episodes of restraint.
Standard 2.5	Services demonstrate the monitoring and quality review of their use of restraint.

Opinion

106. At the outset, it is clear that despite specialist advice and astute medication management, Mr A's behaviour and care were not easy to manage. It is also clear that, in light of Mr A's advanced dementia, there were reasonable grounds to believe that he lacked sufficient competence to give informed consent to many of the services provided to him by Ross Home, including the use of restraint.

107. Where a consumer is not competent to give informed consent to health services, consent can be obtained from a person legally entitled to consent on behalf of that consumer.[19] Although Mrs A held enduring power of attorney for Mr A's personal care and welfare, she was not able to make decisions about significant matters relating to his personal care and welfare,[20] as his mental incapacity had not been certified in the form prescribed by the Protection of Personal and Property Rights Act 1988. In my view, the giving or refusing of consent to restraining Mr A was a significant matter.

108. As Mr A lacked competence to consent to restraint, and Mrs A was unable to consent on his behalf, it fell to his health care providers to provide services that they reasonably believed to be in Mr A's best interests, after ascertaining the views of suitable persons interested in his welfare which, in this case, would include Mrs A.[21] Accordingly, while Mrs A's views about restraining Mr A would not have been

[19] Right 7(4) of the Code.
[20] Section 98(6) of the Protection of Personal and Property Rights Act 1988 states that a significant matter relating to the donor's personal care and welfare means a matter that has, or is likely to have, a significant effect on the health, well-being, or enjoyment of life of the donor (for example, a permanent change in residence, entering residential care, or undergoing a major medical procedure).
[21] Right 7(4) of the Code.

determinative, they should have been ascertained and taken into account when restraint was contemplated.

109. I accept that, in some circumstances, restraining a person may be necessary. I also acknowledge that in Mr A's case, staff acted in what they believed to be his best interests to prevent him falling, injuring himself or being aggressive to others. However, in using restraint, Mr A's health care providers were obliged to comply with relevant legal and professional standards.[22] As stated in the *Restraint Standard*, an unauthorised restriction of a consumer's freedom of movement could be seen as false imprisonment. For that reason, there are specific national standards that apply when restraint is contemplated, to ensure that appropriate professionals carefully consider its necessity and proposed use, alternatives are trialled, and consultation with the resident and his or her family is undertaken.

110. Staff in the Unit at Ross Home did not appropriately implement decisions to restrain Mr A, and demonstrated poor communication and co-ordination, both with each other and with Mr A's family.

Opinion: Breach — Presbyterian Support Otago (Ross Home and Hospital)

111. Ross Home had overall responsibility for ensuring that Mr A received an appropriate standard of care. It needed to have adequate systems, policies and procedures in place, and then ensure compliance with those policies, so that the care delivered to Mr A was safe, appropriate and timely.

Compliance with the Restraint Standard

112. As a facility, Ross Home was responsible for ensuring that the service it provided to Mr A complied with the *Restraint Standard*. Ross Home failed to comply with the *Restraint Standard* in several respects.

113. First, staff were not appropriately educated in restraint minimisation, including de-escalation strategies. At orientation, RN E, RN D and EN F did not receive appropriate education on restraint minimisation, and EN F and RN E received no training at all on restraint use until after Mr A had left Ross Home. I accept that Ross Home employed RN C to co-ordinate restraint minimisation training, and to monitor appropriate implementation of the *Restraint Policy*. However, Ross Home is ultimately responsible for ensuring that education and training on restraint minimisation are, in fact, provided to its staff.

114. Secondly, Ross Home failed to have clear policies and procedures for restraint use. My expert nurse advisor, Ms Sylvia Meijer, considered the Ross Home *Restraint Policy* to be, for the most part, appropriate, but noted that it was not clear from the

[22] Right 4(2) of the Code.

Restraint Policy who was responsible for completing monitoring forms. Ms Meijer noted that facilities usually have guidelines indicating that the Restraint Minimisation Co-ordinator and RNs are responsible for the assessment and evaluation documentation, while care staff who have restraint minimisation education are responsible for completing the monitoring form. Commencement, changes or discontinuation of restraint should be first checked with the RN or Unit Nurse Manager, and then appropriately documented. A policy that made it clear who was responsible for documentation of monitoring restraint would have assisted staff in understanding their roles.

115. Thirdly, Ross Home failed to ensure that staff in the Unit followed the processes for safe restraint practice outlined in the *Restraint Standard*, and further expanded in the Ross Home *Restraint Policy*, when they restrained Mr A, as discussed below.

- Alternatives to restraint were not considered. Mr A's support plan did not identify individualised strategies to manage his behaviour, and there is no evidence on Mr A's file that other causes for his difficult behaviour were investigated.

- When the need to restrain Mr A was identified, staff did not carry out the required approval or assessment processes, which required (among other things) residents and/or their families to be informed about restraint use and their input sought. Mr A was restrained on at least four occasions, without first consulting Mr A or his family or providing them with an explanation, and despite Mrs A and her daughter having previously expressed strong objections to the use of restraint on Mr A. Furthermore, there was no planning, preparation or consideration of restraint by appropriate health professionals. The *Restraint Standard* makes it clear that restraint is to be actively minimised and it is therefore crucial that the assessment undertaken is documented and the key information from this is incorporated into the resident's support plan.

- The episodes of restraint were not adequately documented. Documentation about the use of restraint, if recorded at all, did not always include the reason for initiating restraint, any alternatives to restraint already attempted, the duration of the restraint, and observations and monitoring of Mr A during the restraint. When episodes of restraint occur, these must be documented so that the use of restraint complies with internal policy and the *Restraint Standard*; evaluation by appropriate professionals can occur; minimisation of restraint can be informed by the reasons for past episodes of restraint; and those taking over care can provide appropriate support.

- Ross Home's staff also failed to evaluate the use of restraint on Mr A. Evaluation should have included consultation with Mr A's family. Had the use of restraint been evaluated, Ross Home would have noted the failure to comply with the *Restraint Standard*, and could have acted to ensure such a situation did not recur.

116. The failure to follow policies demonstrates a culture of non-compliance in the Unit, and an environment that did not sufficiently support and assist staff to do what was required of them. Ross Home must take responsibility for failing to ensure that the service it provided to Mr A, through a number of its staff, complied with the *Restraint Standard*.

Assessment, monitoring and evaluation

117. Mr A had low blood pressure soon after admission and was on quinapril, which can cause dizzy spells and fainting. Ms Meijer advised that consequently, blood pressure checks should have occurred routinely. However, Mr A's blood pressure was not reviewed at all in the two months that he was at Ross Home.

118. I accept Ms Meijer's advice that, although Mr A's agitation and frequent falls may have been attributable to his dementia, nursing staff should have investigated precipitating causes, such as high or low blood glucose levels, fluctuating blood pressure, infection, pain, dehydration, constipation, trauma, infections or discomfort. Ms Meijer advised that in order to determine whether a resident is unwell, temperature, blood pressure, pulse, pain levels and blood glucose levels are required to establish whether any subsequent recordings are deviations from the norm. She noted that when residents with fluctuating behaviour escalate in their behaviour, nursing staff in care facilities usually check the resident's general condition against the baseline observations.

119. Where a resident's condition deteriorates, the role of the nurses is to assess and explore reasons. This includes assessment of challenging behaviours. There may be medical or social reasons for the resident's behaviour. More frequent assessments and communication with family becomes necessary. Residents in rest home facilities are vulnerable people, and it is not acceptable to use restraint in lieu of assessing them.

120. After 11 September 2010, the only recorded observation for Mr A was his temperature, despite him falling at least 10 times in the space of one month. In my view, given the frequency of Mr A's falls and general difficulty in managing his care, the assessment, monitoring and evaluation of his condition was inadequate. Ross Home must bear responsibility for the widespread failure of multiple staff in the Unit to appropriately manage Mr A's care.

Documentation and communication

121. Ross Home's *Falls Policy* required documentation of all falls in the resident's lifestyle notes, and the completion of an incident report. The *Incident Reporting Policy* also required challenging behaviour to be recorded on an incident report. Ross Home has been unable to produce incident reports for three of Mr A's documented 11 falls, and eight documented incidents of aggressive behaviour.

122. RN D and EN F advised that copies of the incident forms were not always placed on the resident's file. Ross Home advised that it could not find all of the incident reports and that they may have "vanished" or been hidden. This is unacceptable. In addition, assessments by Ms M and the GP were not always placed on the resident's file and were not reflected in Mr A's support plan. Mr A's support plan was incomplete, and

was not reviewed or updated at all in the two months that he was a resident at Ross Home. The lack of consistent and appropriate documentation and filing systems made it difficult for staff to have an ongoing "picture" of Mr A's condition.

123. Furthermore, the communication systems within the Unit were inadequate. There were four different means of written communication, which were used inconsistently and thus ineffectively. RN C documented instructions around restraint in the communication books and on the Unit whiteboard, whereas Ross Home advised that those instructions should have been documented in Mr A's support plan. I agree that key information should be in the support plan, and it was Ross Home's responsibility to ensure that this happened. Staff deny being aware of Mrs A's wishes and RN C's instructions regarding restraint, despite them being clearly documented in various places. This demonstrates that not only were staff not reading the various written communications, but verbal communication either did not occur or was ineffective.

124. I accept Ms Meijer's advice that, at the time of Mr A's stay at Ross Home, documentation in the Unit was not of a standard expected for such a care facility, leading to fragmented care and disjointed communication. The consistent and detailed use of written communication systems is a valuable tool for all nursing and care staff. Ross Home's failure to ensure that its staff used those tools appropriately compromised the continuity of care Mr A received.

Summary

125. As a facility, Ross Home must take responsibility for ensuring appropriate care is provided to its residents. In my view, given the number of staff involved in the shortcomings over a period of several weeks, the systems and processes at Ross Home, specifically the Unit, were inadequate.

126. Mr A was entitled to the provision of services that comply with legal standards. He was restrained on multiple occasions in contravention of the *Restraint Standard*. By failing to ensure that the service it provided to Mr A, through its staff, complied with the *Restraint Standard*, Ross Home breached Right 4(2) of the Code.

127. Ross Home breached Right 4(1) of the Code for failing to ensure that Mr A's condition was assessed, monitored and evaluated regularly; for not having appropriate documentation and incident reporting systems in place; and for failing to ensure that staff communicated effectively with each other about his care (including restraint).

Opinion: Breach — RN C

128. As Unit Nurse Manager, RN C was responsible for the day-to-day management of the Unit and, according to her position description, for being "a clinical role model". Her position description also made her responsible for:

— implementing effective recruitment, selection, orientation systems;

— ensuring compliance with all legislative, contractual and standards requirements; and
— collation of monthly accident and incident reports.

129. RN C was also the Restraint Minimisation Co-ordinator. In this role, she was required to provide education for staff on restraint minimisation, and ensure staff followed the Ross Home *Restraint Policy*.

130. I have concerns about RN C's orientation and training of staff in restraint minimisation, the development of Mr A's support plan and oversight of his care, and her general management of the Unit.

Support plan

131. RN C was responsible for developing residents' support plans. Her job description required her to support and mentor all staff, including in the development of individualised support plans for each resident in the Unit.

132. Mr A's initial nursing assessment was partially completed by RN E. Baseline observations were recorded within a few days of his admission on a separate form. Ms Meijer advised that the initial care assessment of Mr A was appropriate, but the follow-up and development of a long-term support plan departed from expected standards, as discussed below.

133. Mr A's support plan is unsigned and undated. It is therefore unclear whether it was developed within three weeks of admission, as required by the *Age Related Residential Care Services Agreement*. While RN C says that she did so, Acting Manager Ms L advised that on 28 October she could not find a support plan for Mr A on his file but that one appeared on 30 October. RN D and EN F state that they do not recall the contents of Mr A's support plan.

134. I do not consider I have sufficient evidence to make a finding in relation to when the support plan was developed. However, it is clearly unsatisfactory that it was not signed or dated, the Acting Manager could not readily find it, and the Unit staff were unaware of its content.

135. In addition, there was no evaluation of Mr A's support plan, despite increasing falls and behaviour changes. The GP's and Ms M's assessments were not reflected in the support plan. The support plan did not contain specific de-escalation techniques for Mr A. As Ms Meijer noted, the support plan asked staff to encourage fluid intake of 200mL per day, which is clearly a typographical error because it is not a sufficient daily intake and therefore shows that the plan was not closely checked.

136. The support planning, completed under the direction or supervision of RN C, was not accurately completed. I agree with Ms Meijer that "[i]nstructions to care are disjointed and rationales for care interventions were not validated". In my opinion, RN C, as Unit Nurse Manager, is responsible for the deficiencies in Mr A's support plan.

Management of Mr A's falls and agitation

137. As Unit Nurse Manager, RN C was responsible for overseeing the care provided to Mr A within the Unit. RN C was also responsible for incident reporting and implementing follow-up actions.

138. Mr A was frequently agitated and aggressive. As Ms Meijer notes, nursing staff in the Unit should have investigated precipitating causes for his agitation and frequent falls. However, after 11 September the only recorded observation for Mr A was his temperature. RN C should have ensured that her staff were routinely taking Mr A's baseline observations.

139. In addition, on 7 September 2010 Mr A was identified as being at medium risk of falls, and in his support plan, completed under the direction and supervision of RN C, he is noted as being at high risk of falls. Ms Meijer noted that the interventions listed on his support plan to reduce that risk were "mostly appropriate". However, many of the nursing staff were unaware of the content of the support plan, and it was RN C's responsibility to ensure that they were aware.

140. In one month, Mr A fell 10 times. Competency 2.1 of the Nursing Council of New Zealand's publication "Competencies for Registered Nurses" provides that an RN "provides planned nursing care to achieve identified outcomes", while competency 2.3 requires that an RN "maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework". Ross Home's *Falls Policy* requires a falls risk management plan to be developed according to the findings of the falls risk assessment. There is no such plan on Mr A's file.

141. RN C should have responded to Mr A's increasing falls by ensuring that the falls risk assessments and incident reports were used to create a falls risk management plan, and that this was documented on Mr A's file. RN C's failure to manage and respond to Mr A's falls and aggression demonstrates that she did not provide appropriate clinical direction in the Unit.

Restraint

142. While Ross Home bore overall responsibility for compliance with the national *Restraint Standard*, RN C was the Restraint Minimisation Co-ordinator at Ross Home. In that role, she was responsible for the ongoing monitoring of appropriate implementation of restraint at Ross Home, as spelled out in Ross Home's *Restraint Policy*. The *Restraint Policy* sets out a range of considerations and processes to follow once it is identified that a resident needs to be restrained.

143. Staff in the Unit did not follow the assessment and approval processes outlined in the *Restraint Policy* when they restrained Mr A, as evidenced by the following:

- Mr A, his family, and other appropriate health professionals were not involved in the processes of assessing and approving Mr A's suitability for restraint.
- On 7 and 23 September 2010, Mrs A was not informed that Mr A had been restrained and she was not advised that Mr A was restrained on 7 October until 10 October.

- From 10 September 2010, RN C was aware of Mrs A's strong feelings about restraint, and should have involved Mr A's family in an assessment of Mr A in accordance with the *Restraint Policy*. It also would have been prudent for RN C, on her return to work, as Restraint Minimisation Co-ordinator, to have discussed the risks of bedsides with Mrs A, in light of RN E's record in the initial care plan that Mrs A was "OK with bedsides".[23]
- Staff did not consider or investigate any underlying cause for Mr A's behaviour. There is no evidence in Mr A's lifestyle notes that RN C or other staff routinely checked for extenuating causes for aggravated behaviour, such as fluctuating blood pressure, dehydration, constipation, trauma, or infections.
- Staff in the Unit also failed to adequately document and evaluate each episode of restraint.

144. RN C said that the first time she was aware that Mr A had been restrained was on 8 October. However, she also advised HDC that on returning from holiday, she would read all resident notes for the period she was away. It follows that when she returned from holiday on 10 September 2010, she should have seen that Mr A was restrained on 7 September 2010, as the restraint had been documented by both RN D and Ms M.

145. RN C, as Unit Nurse Manager and Restraint Minimisation Co-ordinator, should have addressed the necessary requirements for the implementation of restraint on 10 September 2010 (when she first became aware of Mrs A's wishes about restraint), and updated the support plan accordingly. The nurses and caregivers needed guidance from RN C on how to handle Mr A in light of his high risk for falls and often challenging behaviour.

146. In addition, RN C was responsible for ensuring that staff in the Unit received appropriate orientation. Ms Meijer notes that this would include orientation in relation to restraint minimisation. Because RN C held restraint minimisation training annually, it was important that any new staff were appropriately educated about restraint use at orientation, as it could be up to 12 months before they received the annual training. RN E, RN D and EN F did not receive appropriate education on restraint minimisation on orientation. Furthermore, while RN D subsequently attended the annual restraint minimisation training, EN F and RN E did not receive that training until after Mr A had left Ross Home.

147. RN C failed to ensure that the *Restraint Policy* was followed in the Unit. There was widespread confusion about when restraint could be used. In my view, the repeated failures by the staff for whom she was responsible indicate a lack of clinical direction and oversight from RN C, as both Unit Nurse Manager and Restraint Minimisation Co-ordinator.

[23] A restless person may try to either get over the gates or over the end of the bed, and in attempting to exit the bed, the person is at risk for entrapment, entanglement or falling from a greater height posed by the side rail.

Documentation and communication

148. RN C acknowledged that she was responsible for supervising and ensuring that nurses and caregivers in the Unit kept adequate documentation. The *Age Related Residential Care Services Agreement*[24] stipulates that all entries into notes need to be legible, dated and signed with designation.

149. RN C was responsible for incident reporting and follow-up actions. There were several entries in Mr A's lifestyle notes for which there is no corresponding incident report, and incident reports that do not have a corresponding lifestyle notes entry. Ms Meijer highlighted that a number of documents were not completed, signed or dated. For example, the incident forms were not consistently completed in the tick box section (which provides for identification of type of incident, such as "bruise" or "non-injury fall") and follow-up sections; and the second half of page two (where the writer identifies whether the incident is one of serious harm and whether this constitutes a hazard) of the incident forms was not completed in 13 of the 16 reports supplied. I also agree with Ms Meijer that follow-up discussions on events related to Mr A's care were poorly documented.

150. Clinical records should be integrated. RN D and EN F said that once incident forms were submitted to RN C, copies would not always be placed on the resident's file. RN C said her instructions not to restrain Mr A were on the staff whiteboard and in a communication book. As I have already discussed in relation to Ross Home, documentation was fragmented and therefore ineffective.

151. Ms Meijer noted that most facilities would have all resident information in their notes. There could be a communication book for household messages, and a GP book for identifying which residents need to be seen by the GP, but the resident notes would illustrate why they needed to see the GP. In the Unit, the RNs used an "RN communication book" (in addition to the staff communication book), which no other unit at Ross Home used and of which facility management were not even aware. Multiple means of communication can compromise continuity of care. As Unit Nurse Manager of the Unit, RN C should have put measures in place to streamline communication within the Unit and ensure that all relevant information was readily accessible and available to staff.

Summary

152. As the Unit Nurse Manager, RN C had a personal responsibility to ensure that the care provided to Mr A in the Unit was of an appropriate standard. However, she did not complete, review or update Mr A's support plan or handle incident forms appropriately. She did not respond appropriately to Mr A's escalating number of falls and instances of agitation or aggression. She also failed to facilitate appropriate documentation and communication systems within the Unit.

153. By failing to provide appropriate clinical direction (including compliance with the *Restraint Standard*) in the Unit, RN C also failed to provide services to Mr A with reasonable care and skill. As the Restraint Minimisation Co-ordinator, RN C failed to

[24] Clause D7.1.

provide appropriate restraint minimisation orientation to all staff, and did not provide staff with appropriate and timely instructions on how to manage Mr A's difficult behaviour. She also failed to follow the *Restraint Policy*, and ensure that the staff for whom she was responsible followed the Policy. In my opinion, RN C breached Right 4(1) of the Code.

Opinion: Breach — RN D

154. RN D became an RN in 1961 and was employed by Ross Home in 2009. Her first two months were spent in another unit at Ross Home, and she subsequently transferred to the Unit. During Mr A's stay at Ross Home, RN D was the sole RN in the unit for some afternoon shifts, and was therefore responsible for directing the care provided by caregivers. In my view, RN D did not provide an appropriate standard of care to Mr A.

155. RN D said she had no formal orientation to either the Unit or the unit she worked in for two months prior to starting in the Unit. She said that her orientation did not cover restraint minimisation. Ross Home could not find an orientation record for her. However, she was an RN with many years of experience and had attended Ross Home's training session on restraint minimisation. As Ms Meijer notes, it can be expected that an RN responsible for a dementia unit is aware of restraint minimisation. RN D did not fulfil her personal responsibility to ensure she followed the necessary procedures, in the following ways.

156. First, RN D did not keep Mr A's care plan updated. Ms Meijer noted that an RN is expected to be involved in care planning. At the very least, an RN should update care plans if a resident's condition deteriorates. In contrast, RN D said that she had nothing to do with residents' care plans.

157. Secondly, RN D was responsible for restraining Mr A twice. On 7 September 2010, RN D was the RN on duty when Mr A was restrained overnight. She recorded in Mr A's lifestyle notes that he was restrained because he was trying to walk but was very unsteady. Her note indicates that an incident form was completed. However, Ross Home could not find this report for HDC, and there is no further documentation in the lifestyle notes relating to this restraint. Mrs A was not informed that Mr A had been restrained.

158. On 7 October 2010, Mr A was restrained again while RN D was the RN on duty. RN D told Ross Home that a caregiver restrained Mr A, but she told HDC that she could not recall the details. I accept Ms Meijer's advice that as RNs are responsible for the oversight of caregivers, RN D was responsible for overseeing the restraint of Mr A on 7 September and 7 October.

159. On both 7 September and 7 October, RN D did not follow the Ross Home *Restraint Policy*. The required assessment was not undertaken, and the use of restraint was not

adequately recorded in the lifestyle notes. RN D should have recorded the reasons for the use of restraint, alternatives considered or tried, and the type, duration and monitoring of the restraint.

160. Despite attending restraint minimisation training, RN D displayed a limited understanding of the *Restraint Policy*. She stated that she understood there was no restriction on the restraint of Mr A in the two weeks following his admission. Furthermore, she told HDC she was not aware that restraint needed to be recorded in the notes or on an incident form (although I note that on 7 September she did record that he was restrained and referred to an incident form, even though it is not clear whether this was actually completed).

161. By not updating the care plan and by failing to follow the *Restraint Policy* when she was responsible for restraining Mr A, RN D breached Right 4(1) of the Code.

Opinion: Adverse Comment — EN F

162. EN F graduated in 1990. She started working for Ross Home in March 2010 but parts of her orientation were overlooked because she was on leave for four months around the beginning of her employment. EN F was the only nurse in the Unit when she worked overnight, and was therefore responsible for directing the care provided in the Unit at those times.

163. On 27 October 2010, EN F and a caregiver were on duty overnight. EN F restrained Mr A with a lap-belt for between 30 and 60 minutes. She made the decision independently, without consulting any senior nurses (including in other units) or management. EN F documented the use of restraint in Mr A's lifestyle notes, recording that Mr A had been aggressive when she tried to settle him in a chair, and had been trying to go into other residents' rooms. EN F told HDC that she restrained Mr A for his personal safety. The duration of the restraint, and any de-escalation strategies instigated prior to restraint, were not documented. RN C informed Mrs A of the restraint episode on 28 October 2010.

164. By restraining Mr A without there being a restraint protocol in place for him and by failing to adequately document the restraint, EN F did not follow Ross Home's *Restraint Policy*. EN F told HDC that she was not aware that Mrs A did not want Mr A to be restrained. Although RN C had left an instruction in the communication book on 13 October 2010, EN F said she could not remember seeing the instruction.

165. EN F did not receive education on restraint minimisation, as her orientation was overlooked when she went on leave early in her employment. She did not meet with the restraint co-ordinator until after Mr A had left Ross Home, when she attended the annual restraint minimisation training.

166. Ms Meijer advised that, as an EN, EN F should not have made an independent decision to restrain Mr A and should have sought advice from an RN when she felt that restraint was needed on 27 October 2010. However, I accept that EN F's failures were mitigated by the lack of education and training she received on restraint minimisation, and the poor systems and clinical oversight in the Unit.

Opinion: Adverse Comment — RN E

167. RN E became an RN in 2008 and was employed by Ross Home in April 2010.

168. On 23 September 2010, RN E restrained Mr A with a lap-belt, recording in the notes that he was put to bed in a chair but would not stay in it. There is no documentation relating to the duration or monitoring of the restraint.

169. RN E documented in the lifestyle notes that Mrs A and Mr A's daughter had agreed to the use of restraint on Mr A when Mr A was admitted to Ross Home. However, that assertion is not supported by the admission documentation, which refers only to bedsides. Mrs A has been clear that she never agreed to the use of restraint, and her wishes were included in the history she gave prior to Mr A's admission.

170. By restraining Mr A without there being a restraint protocol in place for him, and by failing to adequately document the restraint, RN E did not follow Ross Home's *Restraint Policy*.

171. However, RN E's orientation record showed that she did not meet with the restraint co-ordinator within two weeks of her employment as required. RN E did not receive training in restraint minimisation until after Mr A had left Ross Home. I accept that her failures were mitigated by these circumstances.

Recommendations

172. I recommend that Ross Home, RN C and RN D apologise to Mr A's family for their breaches of the Code, by **6 May 2013**. The apologies should be sent to HDC in the first instance for forwarding on to Mr A's family.

173. In my provisional opinion I recommended that Ross Home:

- advise HDC of the outcome of the review of its restraint procedures, including details of the acute restraint forms that were being developed in response to this complaint;

- update its *Restraint Policy* to clearly identify who is responsible for completing the monitoring form;

- advise HDC how compliance with the *Restraint Standard* and *Restraint Policy* is monitored and ensured (including training in de-escalation);

- advise HDC of its current procedures in relation to orientation of new staff;

- advise HDC how causes of agitation and frequent falling (other than dementia) are investigated;

- report back on any changes made as a result of the review of staffing levels;

- provide evidence that resident support plans contain individualised de-escalation strategies, and that all care staff read resident support plans; and

- review its documentation procedures, giving consideration to greater integration of resident notes, including incident reports, and documentation by the nurse practitioner, general practitioner and other specialists.

Ross Home has provided evidence of compliance with each of these recommendations.

174. I recommend that RN C review her practice in relation to her clinical leadership, communication with other staff, and documentation, and advise me by **6 May 2013** of any actions she has taken regarding these matters.

175. I recommend that if RN D returns to nursing, she review her practice in relation to restraint minimisation.

Follow-up actions

176.
- A copy of this report with details identifying the parties removed, except the name of the expert who advised on this case and Presbyterian Support Otago Incorporated (Ross Home and Hospital), will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's, RN D's and EN F'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 Presbyterian Support Otago Incorporated (Ross Home and Hospital), will be sent to the District Health Board, the New Zealand Nurses Organisation, and the College of Nurses Aotearoa (NZ) Inc, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from Registered Nurse Sylvia Meijer:

"Thank you for the opportunity to provide advice on the care provided to [Mr A] by staff at Ross Home and Hospital (RHH), HDC reference number 10/01231. I have been asked to provide an opinion to the Commissioner's Office and I have read and agree to follow the Commissioner's guidelines for Independent Advisors.

This report will begin with an overview of my professional qualifications and clinical experience, followed by an outline of events and my professional opinion on each posed question. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, including additional information made available early 2012, reviewing the relevant literature and my own professional clinical experience of working with older adults. I do not have a conflict of interest with the parties involved.

- *Personal and professional profile*

Nurse Practitioner Older Adult, with prescribing rights; NCNZ 112474 HPI No.: 19 FMZX

I am a Registered Nurse, with a Masters Degree (Mphil.Nursing), 2 Postgraduate Diplomas, in Nursing and Health of Older People, a Postgraduate certificate (Nursing/ Palliative care) and a diploma in Management. My Masters research related to assessment of older people in care facilities. I have been a Registered Nurse for 33 years and am currently working as a Nurse Practitioner, across 3 care facilities and the Central Primary Health Organisation in Levin. As a Nurse Practitioner I work alongside care staff, registered nurses and managers. My clinical work includes assessing, planning, implementing interventions and evaluating care. Staff education, Quality assurance, research and strategic planning are also components of my daily work. Prior to January 2011, I was the Clinical Services Manager of a care facility for 9 years, with responsibilities for clinical oversight, resident care, staff management, education and strategic planning. Incorporated into this position was the role of restraint co-ordinator. My clinical experience includes working with people with multiple co-morbidities and chronic conditions, palliative care, district nursing, surgical and medical nursing and after-hours hospital co-ordinator. Professional involvement includes national facilitator of the Older Person's Nursing Network for the College of Nurses Aotearoa, Membership of the College of Nurses, New Zealand Nurses Organisation and the New Zealand Association of Gerontology. I am involved in National, Regional and community health projects. Conference presentations include national and international presentation on improving care for older people and appropriate health care delivery.

Brief outline of events

[Mr A] was admitted to Ross Home and Hospital on the 7th of September 2010, to the Psychogeriatric care unit. The care notes indicate that [Mr A] was restrain[ed] to a

chair with a lap belt on the 7th of September 2010. [RN D] wrote this entry but the corresponding incident form cannot be found.

[Mrs A] noticed on the 9th of September 2010 that her husband was restrained in a lazy-boy with a lap belt, and noted her concern with the Registered Nurse on duty.

On 23 September 2010 the care notes indicate that [Mr A] was restrain[ed] with a lap belt, [RN E] signed the entry.

Restraint with lap belt in chair on the night of 7–8 October 2010. There was no related documentation but [RN C] told HDC staff that she found [Mr A] with a lap belt. [RN C] was the Unit Manager and the Restraint co-ordinator at the time. On the 26 October 2010, the care notes indicate that [Mr A] was restrain[ed] by Enrolled Nurse EN F.

The referral instructions to me from the Commissioner's office in March 2012 were to further comment on the following, in view of additional information:

- The standard and appropriateness of nursing care provided to [Mr A] by
    - Ross Home and Hospital
    - Unit manager [RN C]
    - Registered Nurse [RN D]
    - Enrolled Nurse [EN F]
- Was the initial care assessment for [Mr A] appropriate
- Did Ross Home have appropriate policies and procedures in place for restraint minimisation
- Comment on the adequacy of staff communication and the appropriateness of the use of three communication books (RN Communication book, [the Unit's] communication book, doctor communication book) and a whiteboard for communication
- Comment on the appropriateness of staff orientation and training, particularly in respect to restraint minimization
- Comment on the documentation by staff generally
- Comment on the adequacy of steps taken to manage [Mr A's] behaviour
- Comment on the steps take by Ross Home to ensure that:
    - Staff were adequately orientated/supervised/trained for their duties
    - Staff were following internal policies and procedures
- In relation to [RN C]:
    - Details of your expectation of a restraint co-ordinator in this kind of facility
    - Whether [RN C] fulfilled her responsibility as a restraint co-ordinator appropriately
    - The adequacy of incident management and reporting by [RN C]
    - Did [RN C] respond appropriately to incidents of restraint, which were documented in [Mr A's] notes, and incidents, which were reported to her
- Comment on the adequacy of change made by Ross Home since these events

- Outline any recommendations for further actions Ross Home or any individual provider may need to undertake

The standard and appropriateness of nursing care provided to [Mr A] by Ross Home and Hospital

The discharge notes from the public hospital, the re-assessment from the Needs Assessment Services Co-ordination, the clinical and lifestyle notes of the Ross Home and Hospital all indicated that [Mr A] had complex medical diagnoses. He required full assistance with all cares, was progressively more restless, with increasing agitation, night restlessness, wandering and falls. Specialist psychiatric services had been involved in his care; however it appears that despite specialist advice and astute medication management [Mr A's] behaviour and care was not easy to manage. [Mr A's] admission to [the Unit] was a measure to manage his care and behaviour in a specialized setting. [Mr A] displayed agitation, restlessness and had frequent falls. Although this can be attributed to his dementia, general measures to determine other or additional precipitating causes were not consistently investigated. In order to determine if a patient is unwell, temperature, blood pressure, pulse, pain levels and blood glucose levels are the basic baseline observations that are required to establish if any subsequent recordings are deviations from the norm. There is a baseline observation available with the notes supplied, however this is on a separate form and not in the initial nursing assessment. The lifestyle notes do not indicate that when falls or exacerbation of conditions occurred, general observations such as blood glucose levels, blood pressure, pulse or temperature were taken to eliminate any contributing physical causes such as high or low blood glucose levels, blood pressure, infection, pain or discomfort. When patients with fluctuating behaviour concerns escalate in their behaviour, nursing staff in care facilities usually check their general condition against baseline observation. For instance when a patient is constipated, has a urinary tract or other infection, has fluctuating blood sugar levels or is in pain, escalating behaviour can be anticipated, (RN Care Guide, 2009). Taking observations may have been difficult during an event when [Mr A] showed to be aggravated, however this could have been checked at a time he had settled down. The organisational policy notes in point 3.3.1 that any underlying cause for relevant behaviour is to be looked at, this was not evident in the notes. I was unable to determine from the supplied notes if staff routinely checked for extenuating causes for aggravated behaviour. Incident forms and care notes indicated that [Mr A] had a high risk of falling; he was noted to have a 'Parkinson-like shuffle' and was often found on the floor. A physiotherapist attended to [Mr A] and the lifestyle plan noted mostly appropriate interventions. The bed was to be at the lowest level, but it was not clear from the notes if this was an ordinary hospital bed or a special low-low bed. The use of a sensor mat was omitted and could have been beneficial, as a number of falls occurred in the bedroom and a sensor mat could have alerted staff that [Mr A] was attempting to get out of bed. [Mr A] had a low blood pressure on admission and was on Quinapril, which can cause dizzy spells and fainting. Blood pressure checks did not routinely occur. The clinical (medical) notes available predominantly dealt with the night restlessness and medication changes. For instance, when [Mr A] sustained an injury to his face in the afternoon of the 8th of October, the GP noted this on the 11th of October 2010. Nursing intervention for frequent falling patients would usually include checking for

other causes such as for example fluctuating blood pressure, dehydration, constipation, trauma, infections and medication review (RN Care Guide, 2009). The input of specialist psychiatric services indicated a close monitoring of the medication. When cognitive functioning fails, the physical, mental, social aspects of health should remain to be incorporated into care. Addressing the causes of behavioural disturbances such as co-morbid medical illnesses, pain, discomfort, need to urinate or move bowels, personal need, environmental factors, is essential to a successful management of behaviour and care planning. (Stokes 2001).

Although practice and processes have since changed and the organisation is meeting contractual requirements, at the time of [Mr A's] stay at Ross Home and Hospital, documentation was not of a standard expected for a care facility. In my opinion, this led to fragmented care and disjointed communication. General observations were not documented consistently. After review of additional information, it is my opinion that the standard and appropriateness of care provided to [Mr A] by Ross Home and Hospital at the time was a mild departure of expected standard. However, [Ms J] notes in her response that internal/external audits and staff education in relation to documentation are now taking place. [Ms H] from Presbyterian Support Otago noted in her reply on 31-01-2012, that a Ministry of Health certification has been awarded for 4 years, which is an indication that systems are in place to ensure good practice and care. These steps are appropriate to ensure that similar issues are less likely to recur.

The standard and appropriateness of nursing care provided to [Mr A] by Unit manager [RN C]

[RN C] noted in her response that she would consider it standard practice that general observations would be taken if a patient became unwell and that staff would take recordings, but these were not documented. There were a number of documents, as noted below which were not completed, signed, or dated. [RN C] noted that due to workload, she often had to rely on others to accept the delegated work. As Unit Manager, [RN C] was responsible for the day-to-day management of the unit, and according to [the Unit] manager position description 'be a clinical role model'. It is accepted practice in care facilities that unit managers have a line of communication to their manager to highlight when a workload is excessive. [RN C] stated that she felt unsupported by management when attempting to address staff education and workload. Documentation supplied by the organisation showed that [RN C] attended numerous education events and attended regular management meetings. [RN C] stated in the HDC interview on 23 January 2012 that she did not have experience in management but was appointed team leader in 2006. She attended a team leaders workshop on 18 September 2007. [RN C] was responsible for restraint orientation and education of new staff. [EN F] and [RN D] both indicated in their interview that they had minimal orientation to [the Unit] or to the practice of restraint minimization.

The Clinical leader/Registered Nurse in charge is responsible to ensure continuous care. There does not appear to be a consistent approach to orientation and education in relation to the use of restraint. The quality cycles and audits of documentation, education and orientation related to restraint would be completed by, or at least be

under the attention of the clinical leader. Follow up discussions on events or any discussions related to [Mr A's] care are poorly documented and assessment and care planning completed by staff under the direction or supervision of the unit manager were not accurately completed. Instructions to care are disjointed and rationales for care interventions were not clearly validated. The management of restraint was not consistent and it can be expected that a clinical leader would seek advice to promote continuity and consistency of care. New Zealand Nursing Council Competency Domains require an RN to show leadership or ask for appropriate advice if unsure about actions. This is not evident in [Mr A's] notes. [RN C] indicated in her letter that she had 2 hours orientation to her role, received leadership training a year later and that the manager was available for advice. Although orientation appears to be insufficient, there is an expectation that educational needs would have been addressed in subsequent performance reviews since 2007. If a clinical leader would require additional support, organisations have a responsibility to manage this to enable staff to provide safe and appropriate care. There is incongruence in the perception of event as seen by [RN C] and as seen by the organisation. The organisation indicated that incident forms were not completed appropriately or lost and timely support was given to the Unit manager through meetings and education. [RN C] indicated in interview that most of the education had to be sourced by her. [RN C] stated in her interview that communication at [the Unit] was of concern and she had addressed this with the manager [Ms G].

After review of additional information, it is my opinion that the standard and appropriateness of care provided to [Mr A] by Unit Manager [RN C] is a mild departure from expected standard of practice. I understand that [RN C] is no longer employed at Ross Home and although [RN C's] current employment situation is mentioned in the Ross Home reply, I am unable to comment on her current employment situation. However, I note from [RN C's] letter that she continues to educate herself and seek professional support, which is an appropriate step to ensure that similar issues are less likely to recur.

The standard and appropriateness of nursing care provided to [Mr A] by Registered Nurse [RN D]

[RN D] stated that she had worked for the organisation for 2 months when asked to work in the unit. She had three duties orientating. [RN D] said that there was no formal orientation and she did not have formal dementia related education. Although the additional information supplied showed a comprehensive orientation programme that is now in place, it is a generic copy. [RN D] stated during an interview on 27 January 2012 that she was given 'poor' support by Unit manager [RN C] and that there was 'little information about restraint'.

Restraint applied to [Mr A] on 7 October 2010 was by a caregiver, according to the incident interview note. As indicated by the position description, Registered Nurses are overseeing support workers. The documentation provided indicates that there was confusion about when restraint could be used and in the initial statement letter [RN D] noted that she was under the impression that in the 'initial two weeks after admission, there was no restriction on [Mr A's] restraint'. [Mrs A] stated on admission that she

did not choose restraint for [Mr A]. Somehow this information was not adequately communicated. Subsequent information noted that [RN D] did not see a note in the communication book that [Mr A] was not to be restrained. During interview on 27 January 2012, [RN D] stated that she 'can't remember restraining him', that she does not exactly remember the time of restraint and she didn't think the restraint needed to be recorded in the notes or on a form. [RN D] notes that she felt unsupported. For instance, access to equipment for routine observations was not readily available, such as thermometers kept in locked cupboards, with no key access to the RN. Registered Nurses on duty have a responsibility to report concerns. Although [RN D] appeared to be aware of how to access GP and Manager input, her knowledge of the Restraint minimization policy and documentation requirements appear limited at the time, as she was under the impression that [Mr A] could be restrained within two weeks of admission and she was unaware of the completion of incident forms. The documentation indicated that a caregiver applied the restraint; however as the Registered Nurse on duty, [RN D] would be responsible for the restraint. In my opinion, it can be expected that a Registered Nurse responsible for a dementia unit is aware of restraint minimization. As per usual practice, an organisation would discuss position descriptions with staff, have these signed by the staff member and have signed copies on each staff member's personnel file. [RN D] also stated that she 'has nothing to do with care plans'; however, a Registered Nurse is expected to be involved in care planning at a minimum to update care plans if a resident's condition deteriorates.

After reviewing additional information, it is my opinion that the standard and appropriateness of care provided to [Mr A] by [RN D] is a mild departure from expected standard of practice and anticipate that the organisational audits and education put in place, prevent similar issues to recur.

The standard and appropriateness of nursing care provided to [Mr A] by Enrolled Nurse [EN F]

[EN F] stated she received two days orientation in each unit. [EN F] noted that the notice on the board regarding [Mr A] not having any restraint was not on the board at the time. Due to [Mr A's] agitation and the staff's need to attend to other residents, [EN F] applied the lap belt restraint. According to the policy, this would not be a decision an Enrolled Nurse would make independently and advice from a Registered Nurse should be sought at the time. [Mr A's] restraint was reported to the Registered Nurse at handover in the morning. [EN F's] performance appraisal indicates that she is a dedicate Enrolled Nurse who takes direction from Registered Nurses. Since the incident, [EN F] has attended restraint minimization education and transitioned to the new Enrolled Nurse scope. During interview on 23 January 2012, [EN F] reiterated that [Mr A] was restless at night and 'never slept in bed' and stated she didn't have a copy of the restraint policy at the time but completed an acute restraint form.

After reviewing additional information, it is my opinion that the standard and appropriateness of care provided to [Mr A] by [EN F] is a mild departure from expected standard of practice. The organisational audits and education put in place, as

well as [EN F's] additional education and awareness of policies should prevent similar issues recurring.

Was the initial care assessment for [Mr A] appropriate?
[Mrs A] noted in the interview on 23 January 2012 that at the time of admission (7 September 2010) a number of items were discussed with the admitting Registered Nurse, [RN E], but was unable to recall what was exactly said and that she was distraught. [RN D] stated during interview that she 'couldn't remember any details' when asked about a care plan. [RN C] noted that she spoke to [RN E] as she was 'not happy with the admitting documentation'. Baseline observations were missing; however, as [Mrs A] noted, she was distraught at the time and the main priority would have been to settle [Mr A]. Observations could have been completed later in the day or the next day and the hospital discharge summary also provided additional information. Residents admitted to care facilities require an initial care plan and this was partly completed on admission. [Mr A's] basic general instructions for care were covered in the 'initial nursing assessment'; however some items were not completed, such as baseline observations. The lifestyle plan, required to be completed within 3 weeks timeframe was not dated or signed off. The *Health and Disability Standards* 8134.1.3:2008 standard 3.5.1 stipulates that a plan should be: 'individualised, accurate and up to date'. [Mr A's] plan did not comply with this Standard. *Health and Disability Standards* 8134.1.3:2008, standard 3.8.3 stipulates that where progress is different from expected, the service responds by initiating changes to the service delivery plan. Evaluation of the lifestyle plan was not available, despite [Mr A's] having increasing falls and behaviour changes. New Zealand Nursing Council Competency for Registered Nurses, competency 2.6 specifies that a Registered Nurse should evaluate a client's progress towards expected outcomes. There is no clear evidence in [Mr A's] notes that his progress had been evaluated or plans adjusted accordingly.

In my view, the initial care assessment of [Mr A] was appropriate; however the follow-up the next day and development of a long-term plan was a mild departure from accepted standard of practice. The organisational audits and education put in place should prevent similar issues recurring.

Did Ross Home have appropriate policies and procedures in place for restraint minimisation?
Policies and procedures in place at the time appear to be appropriate. Staff adherence to the policies and procedures appear to be ad hoc. For instance, the family's wishes not to have restraint were not acknowledged, the documentation stipulated for use when instigating restraint was not followed and staff implemented restraint without prior consent from registered staff or family. Documentation related to restraint was not appropriately completed. The responsibility of restraint documentation is outlined in the policy provided, but there are no obvious documentation instructions about who is responsible for completing monitor forms. Appendix 2 clearly identifies the involvement of the Registered Nurse, Family and Restraint co-ordinator involvement when implementing restraint. Generally, facilities utilizing restraint have guidelines indicating that the restraint co-ordinator and Registered Nurses are responsible for the

assessment and evaluation documentation and care staff with restraint minimization education, generally document on the monitoring form. The Registered Nurse or Unit Manager oversees this. Commencement, changes or discontinuation of restraint is checked with the RN or Unit manager first and appropriately documented. [The Unit] manager's position description outlines that [the Unit] manager is responsible for this as restraint co-ordinator.

After reviewing additional information, I am of the opinion that organisational protocol related to the documentation of Restraint was not followed. The organisation acknowledged that documentation required more attention and a review, including education and regular audits have taken place since. This should ensure that similar issues are less likely to recur. Current policies and procedures and implementation related to restraint minimization appear to be of satisfactory standard and as indicated by the organisation's reply, external Ministry of Health and District Health Board audits in 2011, provided a 'Full Compliance' rating. Continued internal auditing and education, and staff adherence to policies, should prevent similar issues recurring.

Comment on the adequacy of staff communication and the appropriateness of the use of three communication books (RN Communication book, [the Unit's] communication book, and doctor communication book) and a whiteboard for communication.
Fragmented documentation possesses the risk that information regarding care is not observed and hinders continuity of care. Appropriate documentation of the need for restraint, assessment, planning and evaluation of restraint episodes can provide staff with patterns of behaviour related to time and preceding factors that escalate behaviour. In practice, most facilities would have all resident information in their notes; use a communication book for unit related, household type, messages only. A GP book is mostly used to identify which resident needs to be seen by the GP, but the resident notes would illustrate why. Staff interviewed mentioned the variety of message books and whiteboards and there appears to be confusion as to which was used to relay messages.

The use of multiple messages books is not considered good practice and this in my opinion is a mild departure from acceptable practice.

Comment on the appropriateness of staff orientation and training, particularly in respect to restraint minimization.
At the time of [Mr A's] stay at Ross Home, orientation to restraint was ad hoc. [RN D] noted that she had not received any particular orientation to [the Unit] or had restraint education. [EN F's] orientation to the unit was not completed. Orientation and education would generally be part of the responsibility of a clinical leader. Different organisations may have staff employed to deal to these subjects; however as a clinical leader there is a responsibility to ensure all staff working under direction receive the appropriate orientation and education. Clinical Leaders can be expected to have organisational support to achieve this.

Current education and orientation appear to be of satisfactory standard and as indicated by the organisation's reply, external Ministry of Health and District Health

Board audits in 2011, provided a 'Full Compliance' rating. Continued internal auditing and education, and staff adherence to policies, should prevent similar issues recurring.

Comment on the documentation by staff generally
Documentation of the care is not completed in a consistent manner, and this leads to fragmentation of information and disrupts a continuous process of care. For instance:

- On the incident forms, the second half of page two is not completed in 12 of the 13 reports supplied.
- The lifestyle notes entries are dated but no exact time of entry is supplied.
- Lifestyle notes are generally signed off but designation of the person submitting the entry is not consistently supplied.
- Lifestyle note entries are not consistently signed off with a legible name/signature.
- Page 8 of the lifestyle plan notes to encourage fluid intake of '200 mills per day', this would be less than a cup and is clearly a typing error; however this re-iterates that the plan is not closely checked.
- The daughter signed the initial 'Presbyterian Support Otago consent for information, photographs and names', but the wife has EPOA. The form is also not countersigned by a staff member, as is a requirement as indicated by the form.
- The initial nursing assessment is not completed and baseline observations are omitted on the nursing assessment on admission.
- The section for 'restraint' on the initial nursing assessment notes is not completed.
- The Cardiopulmonary resuscitation form was signed by the GP on the 17-9-2010, indicating that [Mr A] 'does not have the mental capacity to make an informed decision'. There is a prompt on the form to go from this statement to part 4 of the form, relating to questions about prior preferences. This section has not been completed.

The Restraint co-ordinator and Registered Nurses are responsible for the assessment and evaluation documentation and care staff with restraint minimization education, generally document on the monitoring form. The Registered Nurse or Unit Manager oversees this. Commencement, changes or discontinuation of restraint is checked with the RN or Unit manager first and appropriately documented. The national Age Related residential Care Contracts stipulates that all entries into notes need to be legible, dated and signed with designation. New Zealand Nursing Council Competency for Registered Nurses, competency 2.3 specifies that a Registered Nurse has to 'ensure documentation is accurate'. In my view, there is the appearance that attention to documentation related to [Mr A's] care is not consistently applied, hindering continuous care provision.

The overall standard of [Mr A's] documentation at Ross Home and Hospital is in my opinion a moderate departure from expected standard of practice. The organisation acknowledged that documentation required more attention and a review, including

education and regular audits have taken place since. This should ensure that similar issues are less likely to recur.

Comment on the adequacy of steps taken to manage [Mr A's] behaviour
All documentation provided indicated that [Mr A's] general condition and behaviour was at times challenging. Involvement from the public hospital was sought and regular visits from a DHB Psychogeriatric Nurse Practitioner and GP were evident in the notes. The care plan documentation was not specific on de-escalation techniques. Most aspects of [Mr A's] fluctuating behaviour and falls could be attributed to [Mr A's] dementia. It is good practice to work pro-actively, and eliminate if there are any other causes for escalating behaviour or falls. Although documentation to evidence that general measures to determine other or additional precipitating causes were consistently investigated and not evident on the incident forms, GP and NP input was sought at least weekly. The organisation was advised to call the family if [Mr A] became unsettled; however it is not evident in the notes that this happened often.

The steps undertaken to manage [Mr A's] behaviour is in my opinion a mild departure of expected standard of care.

Comment on the steps taken by Ross Home to ensure that:
Staff were adequately orientated / supervised / trained for their respective duties
Staff were following internal policies and procedures
At the time of [Mr A's] stay at Ross Home, orientation in general and orientation to restraint was ad hoc. Staff noted during interview that they did not receive any particular orientation to [the Unit] or had restraint education. [EN F's] orientation to the unit was not completed.

Current education, orientation and internal auditing for compliance appear to be of satisfactory standard and as indicated by the organisation's reply, external Ministry of Health and District Health Board audits in 2011, provided a 'Full Compliance' rating. This should ensure that similar issues are less likely to recur.

In relation to [RN C]:
Details of your expectation of a restraint co-ordinator in this kind of facility
A restraint co-ordinator associated with a dementia care unit would be responsible for the orientation, education and ongoing monitoring of appropriate implementation of restraint as spelled out by the policies. It can be expected that this role also include close liaison with families and other health professionals as well as follow up on concerns and complaints. The Unit manager's position description clearly outlines this as part of the responsibilities of this position. Staff noted in their response that education in de-escalation was not supplied. The national Age Related residential Care Contracts stipulate in Clause E4.5 that facilities '…must ensure that all Care Givers directly involved in caring for a Subsidised resident in your Dementia Unit have passed the following (NZQA) Standards 23920, 23921, 22922and 23923'. These education standards provide specific information on managing patients with dementia associated behaviours as well as de-escalation of difficult to manage behaviours.

Whether [RN C] fulfilled her responsibility as a restraint co-ordinator appropriately
The unit manager position description spells out the responsibility related to compliance to legislative and Standard requirements, as well as responsibility for staff education and orientation related to restraint management. Staff identified that they had not received appropriate education and orientation. [Mrs A] mentioned on admission that she would be 'ok with the use of bed gates'. This is noted in the initial nursing assessment and the lifestyle notes dated 7 September 2010. Bed gates however are noted in most facilities as a restraint and carry a risk of injury as the restless person may try to either get over the gates or over the end of the bed. Jacobi, Oppenheimer and Dening (2008) indicate in their textbook that bed gates are considered a physical restraint. Clinical research suggests that bed rails may not be benign safety devices. When attempting to exit the bed by any of these routes, the patient is at risk for entrapment, entanglement, or falling from a greater height posed by the raised side rail, with a possibility for sustaining greater injury or death than if he/she had fallen from the height of a lowered bed without raised bed gates (Jacoby, Oppenheimer, and Dening, 2008). The organisational policy mentions that discussion with family should take place. The reply from [RN C] to the Commissioner also noted that this would be common practice. However this does not appear to have taken place. It would have been prudent for the restraint co-ordinator to point out to [Mrs A] at subsequent meetings that bed gates are a risk.

It is my opinion that the fulfilment as restraint co-ordinator as managed by [RN C], is a mild departure of acceptable practice.

The adequacy of incident management and reporting by [RN C]
As mentioned by the organisation, incident forms were not completed or followed up in all instances. [RN C] noted in her interview that there were a lot of complaints in 2007 and that she had mentioned this to the manager stating that there was a lack of communication.

The incident management and follow up as managed by [RN C] is in my opinion a mild departure from acceptable practice.

Did [RN C] respond appropriately to incidents of restraint, which were documented in [Mr A's] notes, and incidents, which were reported to her?
The organisation noted that a number of incident forms were found when [RN C] left, which were not completed. [RN C] mentioned in the interview that it was her duty as Unit manager to check incident forms. Both [EN F] and [RN D] noted in interview that incident reports were not routinely discussed with all staff. [RN C] or other Registered Nurses in charge signed off 13 out of 13 incident forms. Forms were not always completed in the tick box / follow-up sections. Approval of restraint by family did not take place as acknowledged by the CEO of Presbyterian Support Otago. Despite a request from [Mrs A] not to use restraint, a lap belt was applied on 7–8 October 2010 and again on 27 October 2010. As [the Unit] manager, these complaints should have been addressed at the time of the first incident. The organisation noted their lack of communication, apologized and have put systems in place to remedy this.

The response to incidents of restraint by [RN C] is in my opinion a mild departure from acceptable practice.

Comment on the adequacy of change made by Ross Home since these events
The organisation reviewed their processes, policies and reporting structures. Additional staff education is now provided and another Unit manager appointed. This indicates that the organisation has an awareness of the issues leading up to the concerns related to [Mr A's] care. Provided further monitoring will take place and staff adherence to policies is monitored, the organisation's pro-active systems currently in place should prevent similar issues recurring.

Outline any recommendations for further actions Ross Home or any individual provider may need to undertake.
General note:
The unit manager position description states this requires to be a Registered Nurse, however the description does not refer to the New Zealand Nursing Council competencies/domains for Registered Nurses. The Registered Nurses position description however does. Taking note of the duty roster, where on some days the Unit Manager is the only Registered Nurse on at [the Unit] and the Unit manager has clinical responsibilities, it would be prudent to specify that the Unit Manager also has to comply with the Nursing Council Registered Nurse competencies/domains.

Thank you for the opportunity to comment and review this information. Please contact me if you require further information or clarification.

Yours sincerely
Sylvia Meijer

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Further advice
Sylvia Meijer provided the following further advice on 17 September 2012:

"The Health and Disability Commissioner's Office requested brief advice on:

Orientation to a Unit Nurse Manager of a secure dementia unit, who:

- Had recently graduated as a registered nurse (approximately 4 months prior to promotion to Unit Nurse Manager)
- Worked as an RN in another unit at the same facility for 2 months before being promoted to Unit Nurse Manager
- Had no management training (such as who by, how long, internal/external)
- How would such orientation normally be recorded?

Also, 'you noted in your earlier advice that you would "expect a clinical leader to seek advice to promote continuity and consistency of care". Could you please specify who you would expect the clinical leader to seek advice from?'

Recently graduated as a registered nurse (approximately 4 months prior to promotion to Unit Nurse Manager). Worked as an RN in another unit at the same facility for 2 months before being promoted to Unit Nurse Manager.
Development of competence within nursing is ongoing, including the further development of knowledge and application of skills. Recently graduated Registered Nurses are encouraged to participate in a New Entry To Practice Programme (NETP). District Health Boards (DHBs) provide access to this programme for New Graduate nurses at care facilities. NETP programmes include access to a preceptor and networking opportunities. Generally, DHBs have a Memorandum of Understanding with care facilities and providing payment to care facilities towards new graduate release time.

Since 2005, a number of reviews of nursing education and practice have recommended that New Zealand introduce a structured support programme for newly graduated nurses to benefit the development and retention of nurses. This is common practice overseas as well as in other professions such as teaching, law, accounting and allied health professions. DHBs have developed local programmes of variable size, length and content. New Zealand has a nationally consistent programme to assist new graduate nurses. In general, the 10–12 month NETP programme introduces a consistent set of learning outcomes and provides each new graduate nurse with clinical preceptorship from a senior nurse trained in adult teaching and learning. Each DHB has a designated programme co-ordinator with experience in clinical nursing practice and clinical education. Some DHBs involve accredited nursing schools in the delivery of the learning framework. The Nursing Council of New Zealand's competencies for the registered nurse scope of practice provides the foundation for the NETP programme.

The NETP programme also aligns with the achievement of 'competent registered nurse' on the Professional Development and Recognition Programme (PDRP) framework.

This framework for nursing Professional Development and Recognition Programmes (PDRPs) reflects the unique nature of nursing in Aotearoa/New Zealand. It recognises Te Tiriti o Waitangi (the Treaty of Waitangi) as the founding document of New Zealand. The Health Practitioners Competence Assurance Act (2003) requires the Nursing Council of New Zealand (NCNZ) to ensure competence in nursing practice. This means that from 2005 Registered Nurses are required to maintain a professional portfolio to demonstrate they meet the NCNZ competency requirements.

The PDRP programme identifies:

New Graduate Registered Nurse

Competent Registered Nurse

Proficient Registered Nurse

Expert Registered Nurse

Registered Nurses utilise nursing knowledge, reflective practice and professional judgement to provide competent care and advice in health promotion, maintenance and restoration of health, preventative care, rehabilitation, and care of the terminally ill. This occurs in a range of settings. PDRP programmes define nurses at various levels of development as follows:

The New Graduate Registered Nurse:
Is a newly Registered Nurse with a practising certificate

Is a multi-skilled beginner nurse with theoretical and practical student experiences

Is able to manage and prioritise assigned client care/workload with some guidance

Is reliant on learning from the experience of other nurses and her/his own experience

Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe

Learns and is developing confidence from practical situations

Is guided by procedures, policies & protocols

The Competent Registered Nurse:
Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe

Effectively applies knowledge and skills to practice

Has consolidated nursing knowledge in their practice setting

Has developed an holistic overview of the client

Is confident in familiar situations

Is able to manage and prioritise assigned client care/workload

Demonstrates increasing efficiency and effectiveness in practice

Is able to anticipate a likely outcome for the client with predictable health needs

Is able to identify unpredictable situations, act appropriately, make appropriate referrals

The Proficient Registered Nurse:
Demonstrates in-depth understanding of the complex factors that contribute to client health outcomes

Demonstrates leadership in the health care team

Participates in changes in the practice setting that recognise and integrate the principles of Te Tiriti o Waitangi and cultural safety

Has an holistic overview of the client and the practice context

Demonstrates autonomous and collaborative evidence based practice

Acts as a role model and a resource person for other nurses and health practitioners

Actively contributes to clinical learning for colleagues

Participates in changes in the practice setting

Participates in quality improvements in the practice setting

The Expert Registered Nurse:
Acts as leader for nursing work in unit/facility

Guides others to implement culturally safe practice to clients and apply the principles of Te Tiriti o Waitangi

Engages in Post Graduate level education (or equivalent)

Contributes to specialty knowledge

Acts as a role model and leader

Demonstrates innovative practice

Is responsible for clinical learning/development of colleagues

Initiates and guides quality improvement activities

Initiates and guides changes in the practice setting

Is recognised as an expert in her/his area of practice

Influences at a service, professional or organisational level

Acts as an advocate in the promotion of nursing in the health care team

Delivers quality client care in unpredictable challenging situations

Is involved in resource decision making/strategic planning

It is essential that new graduate Registered Nurses have a comprehensive orientation, mentoring, support, guidance, coaching, planned, professional development opportunities and a safe environment to be able to consolidate competence in the practice setting. New graduate Registered Nurses are encouraged to engage in a formal first year of practice programme that has been designed to ensure development of competence.

A Registered Nurse can progress to become expert in a number of ways, which include relevant clinical experience combined with ongoing professional development activities, increasing self-awareness and reflection on practice. Because progression is competence based it does not have to be linear.

Formal education programmes are available to assist the Registered Nurse to engage in these activities, which facilitates progression to the next level of practice. For competent Registered Nurses to continue to develop, organizational support and support from more experienced nurses in a safe environment, a commitment to some form of clinical/professional supervision, and resourced, planned professional development activities are essential. Organizational educators and/or DHB educators are generally available to assist.

Specific dementia care related education is called for in a number of recent documents, such as the Human Rights Commission 'Caring Counts' (2012) report, The Nursing Times (16 December 2011) and previously in the Ministry of Health (2002): 'Dementia in New Zealand: Improving quality in residential care'. The common theme in these documents is the need for specific dementia related qualifications for staff working in dementia care units. The Age Related Residential Care contract identifies educational needs for care staff. It would be my expectation that Registered Nurses working in Dementia care units would have additional dementia related qualifications to provide appropriate care to residents and appropriately support care staff.

Had no management training (such as who by, how long, internal/external)
Nurses in management and leadership roles provide advice and leadership to others and are mostly experts or proficient nurses. This would include the clinical management of resident care as well as the day-to-day management of the unit and associated staff. Knowledge of staff management is a major component in this.

In addition, essential for nursing leader orientation are a good understanding and knowledge of the organisational mission, vision and values, leadership and staff management skills. Internals and external networks for support are essential. Any orientation should be preceded by a person specific identification of learning needs, followed by a generic and a person specific plan of support. Some of this orientation can be by organisational leaders who hold management qualifications and would take at least one to two years. This would include ongoing mentoring and formal external education such as a clinical leadership postgraduate paper or at least a polytechnic generic management paper to become familiar with basic staff management skills. Support for the new graduate nurse would be essential as the clinical demands of the position would compete with the leadership demands and new graduate nurses are still

consolidating nursing knowledge and 'burn-out' can easily occur. Particularly in relation to the Dementia Unit, a close professional and educational link with the DHB Psychogeriatric service should be in place.

The organisation ultimately takes responsibility for their choice of unit manager and the level of clinical experience and leadership experience the unit manager is able to provide. However, perusing through job descriptions and PDRP levels of nursing competence, I would suggest that unit leaders would be proficient or expert nurses.

How would such orientation normally be recorded?
Orientation would ordinarily be recorded via the organisational orientation programme with additions as identified by learning needs and personalised orientation. A PDRP programme, identifying strengths and weaknesses and providing adequate support would also provide proof of competence and stepwise progression. This would include written evidence of a wider nursing network, with GP practice team nurses and DHB nurses and educators.

Also, you noted in your earlier advice that you would 'expect a clinical leader to seek advice to promote continuity and consistency of care'. Could you please specify who you would expect the clinical leader to seek advice from?
Within an organisation, a clinical framework should identify lines of communication and Best Practice Advice. Organisational policies should mitigate risks for patients/residents, staff and the organisation. The organisational risk plan would identify the skill level of staff and a new graduate nurse in charge of a specialist care unit cannot be expected to provide expert advice on dementia care or on the management of a unit. Generally, organisations have processes to identify care and/or staff concerns and communication with management (clinical and organisational management staff) should be able to advise a newly appointed nurse leader. External clinical and leadership advice can be sought via the DHB Psychogeriatric and geriatric services, from GPs and GP teams and organisations such as the Alzheimer's society. To alleviate any possible and actual clinical or organisational risks, a clinical leader would be able to identify staff and clinical issues promptly and alert their manager to any concerns so that a mitigation plan can be put in place.

Thank you for the opportunity to comment and review this information. Please contact me if you require further information or clarification.

Yours Sincerely

Sylvia Meijer

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