Norfolk Court Rest Home Ltd

Registered Nurse, Ms E

Registered Nurse, Ms F

A Report by the

Deputy Health and Disability Commissioner

(Case 09HDC00987)

Overview

Mrs C and Mrs B complained about the standard of care provided by Norfolk Court Rest Home Ltd (the rest home) to Mrs A (aged 82 years).

Mrs A lived at the rest home from January 2007 until February 2009. Between 26 December 2008 and 21 February 2009, she had four falls. After falls on 9 January 2009 and 30 January 2009, Mrs A was examined by the rest home's registered nurse, Ms E, and no serious injuries were detected. Despite being in a lot of pain, Mrs A was encouraged to walk by rest home staff at Ms E's instruction. After Mrs A's last fall on 21 February 2009, she was examined by a caregiver and, apart from a small graze on her right forearm, no injuries were detected. However, at her family's insistence a doctor was called in to examine her.

Dr J saw Mrs A at 8pm that night. Dr J was advised by caregiving staff that Mrs A could weight bear and, after reviewing Mrs A, formed the opinion that she had no serious injuries. Mrs A was again encouraged to walk despite being in a lot of pain.

On 24 February, Mrs C was concerned about her mother's swollen ankle and asked Ms E if something could be done about it. Mrs C recalls being "brushed off" by Ms E. On 25 and 26 February Mrs A's ankle was noted by the caregivers to be very swollen and, on 26 February, she was taken to the local medical centre for an X-ray. Mrs A was found to have a fractured right ankle (approximately one week old) and a fractured right hip (several weeks old) and was transferred to the public hospital, where her fractures were managed conservatively (plaster immobilisation for the ankle, then mobilisation with a walker).

Throughout the time Mrs A was at the rest home she also suffered from back and chest pain. During the investigation, concerns were raised about the management of this pain.

Complaint and investigation

On 10 March 2009 the Health and Disability Commissioner (HDC) received a complaint about the services provided by Norfolk Court Rest Home to Mrs A. Mrs A's daughter-in-law, Mrs B, had complained to the Ministry of Health on 9 March 2009, and the complaint was forwarded to HDC. On 1 July 2009 HDC received a copy of a second complaint, raising similar concerns. This came from Mrs A's daughter, Mrs C, who had complained to the District Health Board on 11 March 2009.

An investigation was commenced on 17 July 2009. The following issues were identified for investigation:

- *The appropriateness of care provided by Norfolk Court Rest Home Ltd to Mrs A between December 2008 and February 2009.*

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *The adequacy of the information provided by Norfolk Court Rest Home Ltd to Mrs A and/or her Enduring Power of Attorney between December 2008 and February 2009.*

- *The appropriateness of care provided by rest home manager Ms F to Mrs A between December 2008 and February 2009.*

- *The adequacy of the information provided by rest home manager Ms F to Mrs A and/or her Enduring Power of Attorney between December 2008 and February 2009.*

- *The appropriateness of care provided by registered nurse Ms E to Mrs A between December 2008 and February 2009.*

On 17 November 2009 the investigation was extended to include the care provided to Mrs A from August 2008 (previously December 2008).

The parties directly involved in the investigation were:

Mrs A	Consumer
Mrs B	Complainant/daughter in law
Mrs C	Complainant/daughter
Norfolk Court Rest Home Ltd	Provider
Mr D	CEO Norfolk Court Rest Home/Provider
Ms E	Registered nurse/Provider
Ms F	Manager, Norfolk Court Rest Home/Provider
Mr G	Temporary Manager, Norfolk Court Rest Home

Also mentioned in this report:

Mr H	Registered nurse
Dr I	Doctor
Dr J	General practitioner

The following information was reviewed:

Letters of complaint from Mrs B and Mrs C
Responses to complaint from Norfolk Court Rest Home Ltd, Ms E and Ms F
Copy of Mrs A's records from Norfolk Court Rest Home Ltd
Copy of internal investigation carried out by Mr G
Copy of Mrs A's clinical notes from the DHB
Copy of Ministry of Health's audit report dated 6 April 2009

Independent expert nursing advice was obtained from registered nurse Lesley Spence and is attached as **Appendix A**.

HDC

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

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

Information gathered during investigation

Norfolk Court Rest Home Ltd

The rest home provides aged residential care (48 beds) and dementia care (11 beds). Mr and Mrs D are the shareholders and directors of the company (Norfolk Court Rest Home Ltd), and Mr D is the CEO.

During the relevant period, the facility manager was Ms F. Her primary responsibility was to "maintain the continuous, smooth [m]anagement of Norfolk Court with good liaison and communication between all parties involved. To provide total health care in consultation with [registered nurse], Doctors, Residents and families."[1]

The rest home also employed one full-time registered nurse (Ms E) and one part-time (2 days per week) registered nurse (Mr H). They were responsible for the provision and documentation of clinical care to residents (including carrying out clinical assessments of residents, developing care plans, overseeing administration of medications, and keeping families informed). Medical support was provided by doctors at the local medical centre.

Caregivers were responsible for providing daily cares to the residents, alerting the registered nurses (RNs) to any concerns they had about the residents, and carrying out the nurses' instructions.

Mrs A

Background

Mrs A became a resident at the rest home on 4 January 2007. She had pre-existing limited mobility with chronic back and chest pain and established spinal osteoporosis. Previous X-rays had shown a generalised loss of bone density with wedging of some thoracic spine vertebrae. Immediately prior to her arrival at the rest home, Mrs A was assessed by the Needs Assessment and Service Co-ordination Service (NASC) as being a falls risk.[2]

Initial assessment

When new residents arrive at the rest home, the RN is required to carry out a physical assessment (including taking the resident's blood pressure and weight, etc) and an assessment of the resident's pain. The RN is also required to formulate, in

[1] An excerpt from the Manager's job description (undated).

[2] The assessment stated: "Falls risk — because of both muscle weakness and anxiety, this is one of the areas of concern. Recent fall at her daughters — [Mrs A] fell sideways for no apparent reason."

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

consultation with the resident's family,[3] an initial care plan for the resident covering such matters as the resident's medical history, cognition, activity, comfort, nutrition, elimination, skin integrity, allergies, and general health information. These requirements are set out in the rest home's policies on care plans and pain management (which had been last reviewed in March 2006) and in the "Guidelines on resident's admission".

There is no evidence of Mrs A's pain or falls risk being assessed on her arrival at the rest home. Ms E advised HDC that there was no pain assessment tool in use at the rest home at that time.

While there was no policy requiring a falls risk assessment to be carried out, the "Resident checklist" includes a mobility section with an option to circle "yes" or "no" as to whether the resident is a falls risk. Neither "yes" nor "no" was circled on the checklist for Mrs A.

Ms E was on maternity leave when Mrs A arrived at the rest home (4 January 2007). A registered nurse from the public hospital was filling in for Ms E on a part-time basis. However, she was not working on the day of Mrs A's admission, and did not carry out any assessments or write up a care plan for Mrs A. The rest home manager, Ms F, advised HDC that she completed the initial forms as best she could from the information available to her. This was intended as a temporary measure to guide the caregivers until Ms E returned from maternity leave on 12 February 2007, when full assessments could be carried out and a care plan developed.

There is no record of any meetings between the rest home and Mrs A's family in the two years she resided at the rest home.

Pain management

From 31 August 2008 to 25 November 2008 there are more than 70 reports, written by the caregivers, of Mrs A being in pain and having difficulty mobilising because of this.

For instance, between 31 August and 14 September 2008 the following was recorded in Mrs A's progress notes:

> "[Mrs A] has had very bad back pain for the last [three] days. Is having trouble getting on and of[f] the bed. Has been given [P]anadol."
>
> "Given a [P]anadol this am. Back still a bit sore other than that she is fine."
>
> "She moves slowly due to her sore hip and sore back."
>
> "Sore back."

[3] The rest home's policy on consultation with resident/family/whanau/significant others requires that any consultation with the resident's family is to be with the resident's consent (if mentally competent). As well as on admission, the policy lists the other times when consultation is to take place. These include radical changes in treatment or cessation of treatment, referral to another service, significant behavioural problems, and in the formulation of individual care plans.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

"Still has sore back 4 [hourly] [P]anadol [7.30pm] Panadol given."

"Complaining lower back pain. Panadol given."

"Complaining of sore back may need to be seen by doctor been going on a while now."

In Mrs A's "Medication Instruction Sheet" for non-regular drug orders, paracetamol was charted PRN [as needed]. In her Resident Care Plan, dated 16 February 2007, under the heading "Controlling Pain", the following was recorded:

"Objective/goal:	To be pain free
Intervention/Care:	Monitor signs of discomfort or pain and administer medication as per script
Evaluation:	Pain relief administered as required"

Care plans dated 25 June 2007 and 26 September 2008 include the same information regarding pain control with the following additional note under Evaluation: "Refer Short Term Care Plan for Pain Management".

The short term care plan was undated but included the following information:

"Notes: Back pain — trial on Codeine for one month. Regular Panadol …"

On 16 September 2008 Mrs A was seen by Dr I in relation to chest wall pain. On examination he noted "tenderness in right lower posterolateral ribs and chest wall". His assessment was "? Unrecognised trauma" and his treatment plan was to add codeine to the current regime (regular paracetamol), which was to be taken four times a day, and review as required. However, both the codeine and the paracetamol were charted on the "non-regular" medication chart, and the paracetamol remained charted as PRN. According to the medication administration records, the paracetamol and codeine were not given to Mrs A as frequently as had been prescribed (the records indicate that Mrs A received paracetamol and codeine anywhere from one to three times a day).

Between 18 September 2008 and 8 October 2008, there are 27 reports of Mrs A being in "pain", "very sore", "a lot of pain", "uncomfortable", or "in agony" from her back or ribs; and there are also reports of her having difficulty mobilising because of this. Mrs A's records show that she completed the prescribed course of codeine on 27 September. Following this she was given paracetamol PRN (the records indicate that this was given to her between one and three times a day). She was also given a wheat bag for back pain on 18 September 2008, and on 3 October she was given Pamol for a sore back.

On 9 October 2008 Mrs A was taken by her daughter to get an X-ray to investigate her chest pain. According to Dr I's notes, the X-ray confirmed "NBI [no bone injury]

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

and osteoporosis[4] in thoracic vertebrae". Mrs A was seen by Dr I on 14 October, and his assessment was "? osteomalacia[5] ? myalgia[6]". He restarted codeine (15mg, PRN) for the continuing chest pain.

Mrs A's progress notes continue to describe back/rib pain and difficulty mobilising between 14 October and 4 November. On 4 November she was seen again by Dr I. He noted:

> "Still sore in chest wall and back — varying localizations. O/e [on examination]: Tender on the sides of the [chest wall]. Chest — clear. Assessment: Treat as myalgia."

Dr I's treatment plan was to increase codeine to 30mg (four times a day) and give paracetamol (1g, four times a day), and review in one to two weeks time. However, neither of these medications is recorded in Mrs A's "Medication Instruction Sheet" (which contains details of her regular and non-regular medications), and both the paracetamol and codeine remained charted as PRN, despite being prescribed as regular doses. Mrs A's medication administration records, however, show a period of more regular administration (both drugs were administered three to four times a day on most days).

Following Mrs A's consultation with Dr I on 4 November, Ms E documented in Mrs A's progress notes:

> " … keep an eye on her to see if this helps — next step [is] morphine if increased codeine does not control pain".

Between 8 November and 26 December there are more reports of Mrs A complaining of back pain or "appearing" to be in a lot of pain.

The following were inserted in Mrs A's short term care plan under the "Notes" section:

> "10/11/08 — Continue Codeine QID [four times daily]
>
> 10/12/08 — Reduce Codeine BD [two times daily] with Panadol QID
>
> 11/1/[09] — Reduce Panadol BD = Codeine BD 6am/6pm
> = Panadol 12pm/9pm".

On 3 January it was noted that Mrs A had a swollen right leg and that she had complained it was sore. The following day it was noted that she "seems in pain. Says it's her feet". Further reports of pain and slow mobility were made throughout January, both in her progress notes and in the RN communication book.

---

[4] A disease of the bone that leads to increased risk of fracture.
[5] Softening of the bones due to defective bone mineralisation.
[6] Muscle pain.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms E advised HDC that she raised the issue of Mrs A's pain with the rest home doctor, "often weekly when he came for his regular visit", but these discussions were not documented by her or the doctor.

Following discussions with a number of staff involved with Mrs A's care, the rest home advised HDC that Mrs A was "vague" about the location of her pain. This is confirmed by Ms E, who advised HDC:

> "When trying to assess [Mrs A], her pain would travel and be in different places on different days. The doctor would also find this when examining her, as [Mrs A] … would be very vague about where her pain was."

The rest home later acknowledged in an internal investigation into the complaint that there had been deficiencies in the administration of Mrs A's medication:

> "The initial sampling review of medication administration shows poor correlation between reported pain and administration of pain relief charted 'as required' for pain."

Falls prevention and ongoing risk assessment

The rest home's falls prevention policy (this had last been reviewed in October 2006) includes the following statements:

> "It is the duty of every staff member to assist in ensuring the safety of all residents.
>
> …
>
> If during daily cares you believe a Resident has become unsafe mobility wise, this must be brought to the attention of the Registered Nurse immediately. The Registered Nurse will assess the Resident and consult with the Doctor as to further action."

Five care plans were written during Mrs A's time at the rest home. The care plans contained the headings "Mobilising" and "Maintaining a safe environment (Falls, Smoking)". Mrs A was not identified as a falls risk until the third care plan was written on 25 June 2007[7] after her return from hospital with a fractured hip following a fall.

This plan identified a need for a walking frame and assistance to mobilise, and "yes" had been circled under the heading "falls risk". The subsequent falls risk assessment (carried out on 27 June 2007) identified Mrs A as being "low risk" for a fall.

Mrs A's fourth care plan was written on 26 July 2008 and, under the heading "Mobilizing", her objective/goal was to "[m]aintain regular exercise to maximum ability". It is also recorded that "[Mrs A] uses a walker when mobilising and

---

[7] The first care plan was undated, and the form does not indicate who developed the plan. The second care plan was developed by Ms E on 16 February 2007.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

sometimes is unsteady on her feet". Under the heading "Maintaining a safe environment," the objective/goal is "[t]o maintain a safe environment". Neither "yes" nor "no" have been circled under "falls risk". It is noted that "[Mrs A] will often not use her walker when going to her toilet, it is at these times she has had falls in the past". Mrs A's fifth care plan (dated 26 September 2008) contains the same information as her fourth care plan.

Management and follow-up of falls

Mrs A fell four times between 26 December 2008 and 21 February 2009. The following was recorded in her progress notes by a caregiver on 26 December 2008:

> "[Mrs A] had a fall this afternoon. A&I [Accident/Incident] form filled out. She seems still in pain with her back, maybe advisable to keep checking or supervise when toileting."

In the accident/incident report[8] the caregiver recorded the following:

> "Description of Accident/Incident: When I went into [Mrs A's] room to collect her cup after afternoon tea found [Mrs A] on the floor. Said she had fallen when trying to get back on the bed after the toilet. She had fallen on her bottom and hit her head on the ranch-slider.
>
> Extent of injuries: None at time of check, but complaining of a sore back and bottom as well as a sore head. Checked by RN. Said it was fine.
>
> Treatment given: Helped her back on her bed and checked by RN. No injuries visible, given TLC [tender loving care] and [taken by wheelchair] to dinner. Continuously checking she is okay. She reassure[d] me she was fine."

The caregiver recorded that she notified RN Mr H of the fall.

In the days following the fall, there are reports of Mrs A "moving very slow"; "[not] keen on walking"; being "wheel-chaired"; "painfully slow"; "seems to be in a lot of pain"; and it was observed that her right leg was swollen and sore. Mrs A was reviewed by Dr I on 7 January in relation to an unrelated ailment (oedema). There is no evidence that he was specifically alerted to Mrs A's pain or a lack of mobility at this consultation.

RN Ms E advised HDC that:

> " … [Mrs A] was asked to use her bell when wanting to get up so assistance could be given. [Mrs A] was reluctant to use her bell, but we continued to remind her to do so. Restraints were not considered … as I felt [Mrs A] was mentally capable to understand the instructions of using her bell."

[8] The rest home's accident and incident reporting policy requires all accidents and incidents to be reported and recorded on the appropriate forms as soon as practicable after the event. The accident and incident report form contains space to write a description of the accident/incident; extent of injuries; treatment given; and person/s notified of accident/incident.

HDC

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs A's daughter, Mrs C, advised HDC that when she asked her mother to use the bell, her mother replied that "no one ever comes", so she had given up using the bell and tried to manage on her own.

January falls

On 9 January 2009 Mrs A had another fall. RN Mr H recorded the following in the progress notes:

> "When checked at [midnight] [Mrs A] was found sitting on the floor at the end of her bed. No apparent injuries at that time. Caregivers put her back into bed. Incident report states she was a little shaken but otherwise OK. When later checked whilst she was being showered she was found to have a minute skin tear on her left shin and some bruising has now appeared on her right arm and elbow. Cosmopor dressing applied to shin. Cold compress to arm. Her daughter ([Mrs C]) has been fully informed by me."

The accident/incident report was filled out at 6am by a caregiver and recorded the following:

> "Description of Accident/Incident: Opened door of room. [Mrs A] was sitting on the floor at the end of the bed. Said she was going to the toilet her walker had fallen over. We picked her up and checked her over. Seemed OK. A little shaken.
>
> Extent of injuries: NIL. None we could see. [At 10.30am RN [Mr H] recorded:] O/E [on examination] minute skin tear (L) shin — and bruising to (R) elbow. Cosmopor dressing applied.
>
> Treatment given: TLC and put back to bed."

RN Mr H noted on the report that Mrs A's daughter "has been advised by RN".

Mrs C advised HDC that this record is incorrect: she was not advised of her mother's fall and could not have been advised because she was away at that time.

In the days following this fall there are reports of Mrs A being in "lots of pain", "sore", and moving "very slow".

A falls risk assessment was carried out on 19 January 2009. This identified Mrs A as being a low falls risk. The following day Mrs A was reviewed by a doctor in relation to her oedema. Again, there is no evidence of rest home staff alerting the doctor to Mrs A's pain and lack of mobility.

On 31 January 2009 Mrs A suffered a further fall. Her progress notes were written by a caregiver and record the following:

> "Has been found on floor. Bruised on eye and bump on back of head at [6.50am] approx.
>
> …

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> [Mrs C] [daughter] was advised of the fall [Mrs A] had at [3.10pm]. [Mrs A] is still in pain, says it's her knees, leg and feet seem very swollen; spoke with her daughter this [afternoon] about [Mrs A's] fall. Also found a skin tear on [Mrs A's] left arm, notified [a caregiver] to dress it, assisted with care. Ate very little this evening and feeling miserable.
>
> …
>
> No concerns about [Mrs A's] fall her legs very swollen is still in pain but [Mrs A] no[t] complaining."

Mrs C advised HDC that this was the first time she had been informed by Norfolk Court Rest Home about any of her mother's falls.

February falls
On 2 February 2009 the following notes were written in the RN Communication book by a caregiver:

> "[Mrs A] [right] foot and leg still swollen ?needs X-ray."

On the same day Ms E wrote the following in Mrs A's progress notes:

> "Nursing: Full check after fall on 31.1.09: Good [range of movement] in [left] leg. Small bruise on outer aspect of [left] knee. Small amount of bruising to [left] lower rib area with some grazing — painful to touch — small bruise to corner of [left] eye — [Mrs A] able to weight bear — is already on codeine and Panadol for pain."

The accident/incident report was filled in by a caregiver at 6.50am and recorded the following:

> "Description of Accident/Incident: Found fallen on floor by bed returning from the toilet.
>
> Extent of injuries: Bruising upper left eye and bump on back of head and the [afternoon] shift found the skin tear on the [left] arm.
>
> Treatment given: [Caregiver] was notified and has checked her over."

No RN or relatives were recorded as being notified.

A second accident/incident report relating to this fall was filled by a caregiver at 6pm. The caregiver recorded that a skin tear had been found on Mrs A's left arm when putting her into bed. The tear was cleansed and a Cosmopor dressing was applied.

In the days following this fall, there are numerous reports of Mrs A being in pain; and her legs are noted to be "very swollen". There are also several reports of Mrs A refusing to walk or walking "under protest", and requiring "a lot of encouragement" to walk.

HDC

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On 21 February 2009 Mrs A had another fall. The following was recorded by a caregiver in her progress notes:

> "[Mrs A] was up for breakfast, then when returning to her bed found her on the floor. A&I form completed. Didn't want to get dressed & resting on bed.
>
> …
>
> [Tried] contacting [Mrs C] to inform her about [Mrs A's] fall and got answering machine, so message left.
>
> …
>
> Feet and legs are very swollen & in [a lot] of pain."

At 3pm another caregiver recorded the following:

> "Rang by ([Mrs C's] husband) … to ask how [Mrs A] was. I advised him that she is fine, has a small graze on right forearm, no other injuries detected. Advised him that I did not see the necessity to call a doctor. He was happy with my decision. At [5pm] [Mrs A's son, Mr B] rang and asked what has happened to his mother and questioned our standards of care and our ability to care for his mother. I explained that I have followed our protocols and have thoroughly checked [Mrs A] and she only has a little red mark on her right forearm. NAD [no abnormalities detected] … I was then asked why I had not [telephoned] the doctor. I said that I did not think it was necessary. He then said he was a nurse and was quite aware of how things do not show up until hours later and what qualifications did I have to make the judgement of not calling the doctor. I repeated I would be more than happy to give him a concerns form to fill out and if he wished at his request I would call a doctor. He then said he lived in [another region]. So I asked him for his name and telephone number and I would get the manager to ring him on Monday … The phone rang again … It was [Mr B] … who requested a doctor be called to see [Mrs A] which I did … [Dr J] arrived at [8pm]. [She checked Mrs A] and completed her examination at [8.15pm]. No injuries or serious concerns. Right leg and ankle swollen, warm to touch but has been reported and addressed on several occasions. [Dr J rang son] and spoke to [Mrs B] (daughter-in-law) and [Mrs C] (daughter) was here at time of visit."

Medical review

Dr J advised HDC that she was not Mrs A's usual GP. She was asked to review Mrs A by the rest home (at the family's request) on the evening of 21 February. She was advised by a staff member at the rest home that Mrs A had longstanding problems with pain in her back, legs and feet, and swollen legs, and had had recent falls, including a fall that day. Prior to visiting Mrs A, Dr J reviewed Mrs A's notes at the practice and noted her history of osteoporosis, chest and back pain and pitting oedema.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On arrival at the rest home, Dr J asked Mrs A if she had any pain, and she responded that her back was sore. Dr J did not get Mrs A out of bed to walk, but the caregivers assured Dr J that Mrs A had been walking and weight bearing in her usual manner. Staff also informed Dr J that Mrs A's mobility was limited because of generalised pain, which pre-dated her fall that day.

Dr J examined Mrs A, noting that she was pale but warm and not distressed. Both ankles were swollen — the right one was more swollen than the left and was pinker but not "unduly hot" nor "particularly tender". Dr J did not note any obvious deformity and was advised by rest home staff that Mrs A's ankles were less swollen than usual.

In light of her findings, Dr J did not consider it necessary to initiate any further investigations, as this would involve Mrs A travelling a distance to the public hospital and facing a potentially long wait. Although Dr J was aware that several falls in a patient with osteoporosis could result in bone fractures, she was "reassured by the fact that Mrs A could weight bear".

Dr J made the following notes:

> "21.2.09 Had a fall today — found wedged between bed and wheelchair on bottom. No obvious serious injury. Since then weight bearing and eating. [On examination] in bed, pale warm to touch. No obvious injury. [Right] ankle swollen and pink (long standing apparently) spoke to [Mrs C] (daughter) and daughter-in-law [Mrs B]. Reassured nil serious."

The accident/incident report was filled in by a caregiver and recorded the following:

> "Description of Accident/Incident: Walking past [Mrs A's] room and seen her sitting on the floor between the bed and wheelchair. Was trying to get off the wheelchair and onto the bed and fell which left her on the floor.
>
> Extent of injuries: Feeling a bit sore on right side of body and arm a bit red.
>
> Treatment given: Rested back on bed, TLC given and body checked. No injuries showing. See attached Dr notes."

Follow-up care

The following notes were written in Mrs A's progress notes over the next couple of days by caregivers:

> "22.2.09 PM … She refused to walk from nurses' station to her room. Let her sit on [seating in corridor] then wheel-chair to bedside.
>
> …
>
> 23.2.09 PM [Mrs A] had great difficulty to stand and weight bear. Appears she has no strength to stand let alone walk. Transferred on and off toilet with great difficulty. [Taken by wheelchair] everywhere."

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms E advised HDC:

> "As staff were not aware that [Mrs A] had any fractures, she was encouraged to walk with assistance. Staff would walk behind her with a wheelchair so when she felt that she had had enough of walking they would wheel [Mrs A] the rest of the way."

Ms E wrote the following in Mrs A's progress notes on 24 February 2009:

> " … Please 2x caregivers for cares as [Mrs A] refusing to weight bear. Says she will fall. I phoned [Mrs C] and left a message on answer machine."

Mrs C advised HDC that on 24 February 2009 she asked Ms E about her mother's "very swollen right ankle". Mrs C recalls Ms E telling her that she had not seen Mrs A that day and was not aware how swollen Mrs A's ankle was. Mrs C also recalls Ms E explaining to her that the swelling could be caused by medication or lack of exercise. Mrs C then told Ms E that "something needed to be done now" but Ms E brushed her off, saying it was late in the day and she [Ms E] would need to speak to someone. Ms E's cell phone then rang and the issue was not discussed further.

Ms E recalls Mrs C arriving late in the afternoon on 24 February. She recalls telling Mrs C that "the oedema would not be helped by her mother's reduced mobility".

Two days later, on 26 February 2009, Mrs A was taken to the medical centre to have her right leg and foot X-rayed. The X-ray revealed that Mrs A had a fractured tibia and fibula of the right leg.

It is unclear who requested the X-ray. Ms E advised HDC that she reviewed Mrs A at a caregiver's request and subsequently ordered an X-ray. She advised HDC:

> "The ankle appeared different to what I had seen two days previously. It was obvious to me at that time there was something more than oedema wrong with her and I requested an X-ray. This was done later that day and confirmed she had a fracture."

A caregiver wrote the following in Mrs A's progress notes on 26 February:

> "[Mrs A] taken to [the Medical Centre] for X-ray of [right] leg and foot after caregiver's request. R/N organised X-ray."

However, Mrs A's daughter-in-law, Mrs B, advised HDC that the X-ray was done at the family's request.

Transfer to the public hospital

Mrs A was admitted to the public hospital on 26 February, following her X-ray at the medical centre. Her fractures were confirmed and she was also found to have a fractured right hip, which appeared to be several weeks old.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs A was transferred to the local hospital on 3 March 2009 for follow-up care and was discharged on 12 March 2009 to a different rest home.

Ms E advised HDC that, although it was not always documented, she did discuss Mrs A's increased falls on a weekly basis with the rest home doctor.

Ms F, the manager of Norfolk Court Rest Home, advised HDC that it was not until the day Mrs A was transferred to the public hospital that the RN or doctor indicated to her "any issues involving the care of [Mrs A]".

Scabies outbreak

One of the complaints received by HDC alleged that Mrs A was diagnosed with scabies during her admission at the public hospital. It was later revealed that the rest home had had an outbreak of scabies but had not alerted the hospital to this.

Although Mrs A was suspected to be suffering from scabies when she was at the public hospital, subsequent pathological reports were negative for scabies.

The rest home advised HDC that:

> " … in the week of 23 February 2009, three residents had presented with 'Scabies like papules'. The doctor ordered skin scrapings which were collected on 25 February 2009. According to a copy of the laboratory report, the results confirming [the presence of scabies] were reported to the GP on 26 February 2009 at [5.02pm]. The GP phoned the Manager that night to confirm the findings. [Mrs A] had left the service prior to the confirmation of Scabies. [Mrs A's] progress notes do not evidence that she was symptomatic at the time of her transfer."

Outbreak management/infection control policies and procedures

The rest home's policy on outbreak management (this had last been reviewed in February 2007) lists common infections and the steps to be taken to reduce the risk of the infection spreading. The policy includes a section on scabies. It requires, amongst other things, washing of the linen and clothes of infected people; the application of a prescribed cream; and treatment of staff who have had contact with the infected person in the preceding week.

Rest home staff

Ms E

Ms E completed her nursing degree in 2005. She became registered in December 2005 and in January 2006 she commenced a graduate programme in paediatrics. On 18 July 2006 she began work at the rest home.

Ms E advised HDC that on her first day at the rest home she was oriented to the facility by another RN, who was then working there one day a week. The orientation took four hours. Ms E worked four days a week at the rest home until she went on maternity leave on 10 November 2006. On 12 February 2007, she returned to work as the sole RN.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms E advised HDC:

> "I felt somewhat overwhelmed by this and requested another Registered Nurse be employed as I felt I was unable to carry out my duties effectively. I continued to request verbally to the Manager that I needed assistance and that I was finding it tiring and was not able to keep up with my work load."

The rest home employed a second RN during 2007, to assist Ms E while she caught up on paper work. After three months the second RN resigned. Ms E advised HDC that she requested assistance on several occasions, but when this was not forthcoming she handed in her resignation as she felt she could "not continue to carry out the duties required of [her]".

However, after a discussion with the rest home's CEO, Mr D, Ms E agreed not to resign. She was given one week's stress leave and another RN was employed to work two days per week.

Ms E advised HDC that she was not provided with any clinical support until after the complaints from Mrs A's family were received in March 2009. At that time she "was appointed a professional mentor who has been a great help just to know there is someone I can call for advice/support".

During her employment at the rest home, Ms E attended various seminars and workshops, including a four-hour workshop on wound management; a one-day seminar on diabetes and depression; and a one-day registered nurse seminar. She also received in-house training on a variety of issues, including informed consent; risk management; residents' rights; restraint and elder abuse; and a gerontology seminar.

Ms E advised HDC:

> "I feel during the past three years I have done the best I could have with the lack of experience, support and guidance in my role as a Registered Nurse in this facility. I have taken my job seriously and I understand my short falls and am the first to admit them. My documentation has been below standard and I am now realising the importance of good documentation, even down to communications I have had with my employers. I am sincerely sorry for any wrongs I may have contributed to and my apologies go out to the family for the pain they have endured."

In July 2009 Ms E resigned and left Norfolk Court Rest Home.

Ms F

Ms F worked as an ambulance officer for 16 years and also as a clerk/administrator. In 2001 she was initially employed by the rest home as office manager, during which time she completed an Aged Care Education Core Programme. She was appointed to

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the position of Manager in 2002 and since then has attended in-house education sessions on a variety of issues[9] and achieved various NZQA standards.[10]

Ms F's job description indicates that she was responsible for "Managing Norfolk Court Rest Home in a manner which ensures all statutory and contractual obligations are met". The following are included in the list of "Primary Objectives" and "Performance Indicators" for the role:

- Ensuring that "all clinical and non clinical services at Norfolk Court are delivered to the Residents in a safe and dignified way … ensuring … their individual needs are met"
- Ensuring "staff are knowledgeable of, and their work-practices reflect, the Code"[11]
- Ensuring "appropriate written information is available to residents and their representatives as required by the Code …"
- Ensuring "staff are competent to carry out assigned tasks and responsibilities"
- Promoting "positive and therapeutic resident care by a Multidisciplinary team model"
- Ensuring that "services are provided to a level and quality to ensure at least 95% Resident satisfaction with services at all times".

Ms F said:

> "When new residents are admitted, I am responsible for the administrative aspects of the admission process. I meet and greet them and show them to their room. I also ensure that the appropriate personal information and contact person is available and that an agreement for admission is signed … The Registered Nurse takes over from me and is responsible for undertaking the clinical assessment and documentation and providing instructions to the caregivers.
>
> …
>
> I relied heavily upon the registered nurse to work with the contracted medical service ([the] Medical Centre) to ensure the health needs of residents were met in a timely and competent manner.
>
> My involvement in clinical matters was as a support to this team."

With regard to support and training provided to her by the rest home, Ms F advised HDC:

---

[9] These include: risk management; restraint and elder abuse and neglect; leadership/team building; dementia; informed consent and advance directives; and challenging behaviour.

[10] These include: managing acute cardiac events in ambulance services; treating hypovolaemic shock in ambulance services; workplace safety; wound healing — prevention of pressure sores; health and safety — employees' responsibilities.

[11] The Code of Health and Disability Services Consumers' Rights.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> "Training has been very limited. I have numerous times requested to attend the [area] management meetings held monthly by Healthcare Providers New Zealand Inc [the nearest main centre], plus requested that I attend Conference etc. This has not been granted.
>
> …
>
> I feel that I have not had the opportunity to increase my knowledge as I have not been given any peer support. I have progressed through the introduction of Certification by myself using the information given to me by Residential Care NZ Ltd/Healthcare Providers Inc.
>
> …
>
> I really appreciate having [Mr G][12] assisting us with amending and updat[ing] our policies and procedures. His expertise and professionalism is outstanding and I wish I had received support such as his earlier."

Ms F also expressed frustration at the inconsistency of audit reports, which she believes impacted on her ability to monitor the rest home's compliance with its various obligations. She advised:

> "I would like to express my concerns about the number of different opinions given by the various auditors who have visited Norfolk Court since certification i.e. MOH, DHB and independent auditors. We have changed our systems at least three times because of comments made by them. They do not appear to be consistent."

Staff orientation policy
The rest home's staff orientation policy (this had last been reviewed in October 2003) states that new staff will, in their own time, undergo an orientation programme, one hour in duration. During this hour, staff are required to familiarise themselves with:

- the building
- occupational health and safety routines
- individual routines
- policies and procedures

After orientation of the building, the staff member will be oriented to "[c]aregiving and written aspects of the position"; and a checklist will be completed.

The new staff member will be oriented in the "general care of the elderly" by completing two to three shifts with a buddy.

[12] Temporary manager, appointed 11 April 2009 by the DHB.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Communication between RN and Manager
Ms E and Ms F advised HDC that they had contact at least once a day regarding a variety of issues such as the day-to-day running of the rest home, any concerns Ms E had about staff or residents, reviewing accident/incident reports, and infection control.

Communication between caregivers and RNs
The rest home's policy on communication about residents by staff (this had last been reviewed in May 2003) contains the following information:

> "It is policy of Norfolk Court to ensure that the reporting of Residents to staff is carried out regularly, both written and orally at each shift change and as events occur which may necessitate staff being aware of that knowledge.
>
> All written reporting and records of Residents will be kept up to date and reviewed regularly.
>
> …
>
> All reports are to be documented in Daily Progress Notes and documentation noted on 24hr Alert. Notes can also be written in [RN] Communication Book."[13]

The rest home's policy on written and verbal reports on residents by staff (this was reviewed in March 2007 and March 2008) includes:

> "At commencement of all shifts, Staff must read Staff Communication Book, 24 hour alert, and the daily diary … The Senior is to read the [RN] Communication Book and pass on any relevant information to carers.
>
> …
>
> At the end of every shift each Caregiver will note on the handover report any matters that need to be brought to fellow staff. This shift handover report will also be read by the Registered Nurse. The nurse is also able to document any changes to care plans etc for staff to read and refer to."

Caregivers would routinely document observations about residents in the resident's progress notes, and any specific concerns they had about residents would be documented in the RN Communication Book.

Ms E advised HDC that the caregivers were directed to verbally inform the RN on duty of anything that required addressing, or notes that needed to be read, but this did not always happen and as a consequence "things [were] missed by the RN on duty".

Ms E did not write routinely in the resident's progress notes but would document any doctors' visits and changes to the resident's medication.

[13] The rest home advised HDC that this book would be used for communication between RNs, and caregivers would also use the book to advise the RNs of any concerns they had.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

DHB and Ministry of Health audits

The DHB advised HDC that it carried out a routine audit at the rest home on 28 March 2007. This identified some areas of partial compliance, and the rest home submitted evidence to satisfy these areas on 17 May 2007.

On 2 May 2007 a re-certification audit was completed by International Certifications Ltd, an auditing agency engaged by HealthCERT.[14] The audit report identified partially attained criteria in relation to: assessment tools (policies and procedures); exit/discharge/transfer forms; medical reviews; medication management; and infection control (documentation and review of data).

The audit report identified unattained criteria in relation to: integration of residents' notes and files; and policies and procedures for monitoring and re-evaluating the use, effect and impact of restraint.

A surveillance audit at the rest home was completed on 13 May 2008 by the same auditing agency. The previously identified "partially" or "unattained" criteria were identified as being "fully attained", but further criteria were found to be partially attained in relation to: activities assessment plans for residents; storage of medication; and self-medication policy and procedure.

Subsequent events

Ministry of Health inspection report

After Mrs A's daughter-in-law, Mrs B, complained to the Ministry on 9 March 2009, HealthCERT carried out an unannounced inspection at the rest home (on 19 March 2009).

The report, dated 6 April 2009, identified a number of shortcomings at the rest home requiring corrective action, including issues relating to:

- Residents' needs assessments
- Supervision/mentoring for the RN
- Reducing exposure to avoidable risk
- Analysis of incidents, accidents and other untoward events
- Short staffing and lack of qualified staff in dementia unit
- Lack of involvement by residents' families in care planning
- Insufficient documentation
- Inappropriate use of restraint
- Pain assessment and management
- Falls prevention
- Medicine management
- Lack of multidisciplinary approach to care
- Care plans not reflecting goals and interventions required to meet goals

[14] HealthCERT is the section of the Ministry of Health responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appointment of temporary manager

The inspection report demonstrated that the rest home had failed to meet a number of its contractual obligations as set out in the Aged Residential Care service agreement it had with the DHB. Consequently, the DHB appointed Mr G to the position of Temporary Manager of the rest home. Mr G's appointment was initially for three months, commencing 11 April 2009 (this was later extended for a further three months).

Mr G's role was to produce and oversee the implementation of a "Corrective Action Plan" to address the identified failures by the rest home to meet its statutory and contractual obligations.

The DHB subsequently contracted Mr G to visit the rest home monthly (until July 2010). He also attends meetings at the rest home for quality and risk management, and clinical management, and he reviews quality and risk management activities.

The DHB advised HDC:

> "HealthCERT and [the] DHB have made a commitment to keep each other informed of developments at Norfolk Court Rest Home. To date, this collaborative approach has worked in a satisfactory manner."

Re-certification audit

On 12–13 May 2009, International Certifications Ltd carried out another re-certification audit at the rest home. This audit identified many of the issues already picked up by HealthCERT's recent inspection report, in particular: insufficient staffing levels; lack of clinical support; need for analysis of accident and incident reports (quality improvement); inadequate care plans; and restraint (assessment, monitoring, re-evaluation and staff training).

The report advised that the temporary manager was in the process of employing three new staff members and was developing new staff rosters at the time of the audit.

Internal investigation and changes made

Mr G provided HDC with a copy of an internal investigation into Mrs B's complaint. Mr G advised:

> "As a result of reviewing the services delivered, we have identified a number of shortcomings in Mrs A's care, for which we unreservedly apologise. These shortcomings relate to:

- Clinical Governance and Supervision
- Clinical Documentation
- Pain management
- Medication Management."

The internal investigation reached the following conclusions with regard to the management of Mrs A's pain:

HDC

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Poor evidence of follow-up of caregivers' observations;
- Care plans do not adequately address ongoing reported pain;
- Some evidence on pharmaceutical intervention — no mention in care plan on non-pharmaceutical interventions (progess notes indicate wheat pack applied for pain on 18 September 2008);
- Confusion in prescription orders — for example, paracetamol order on medication prescription form charted as "QID [PRN]"; however, elsewhere (on the short term care plan) it is recorded that it is to be given regularly QID (10 November 2008), then on 10 December 2008 it is reduced to BD;
- Poor evidence of administration compliance with medication orders.

As a result of its findings, the rest home advised that it was implementing the following quality improvement measures:

- Introduction of monthly quality and risk management meetings;
- Introduction of monthly clinical management team meetings (comprising the manager, registered nurse, and specialist dementia unit coordinator);
- Revision of the pain management protocol;
- Upskilling staff on management of medicines;
- Upskilling staff on pain management;
- Implementation of an auditable multidisciplinary team review process;
- Revision of the clinical forms;
- Implementation of a specific care plan for pain management;
- Improved handover procedures (a written handover report to be completed, and a verbal handover given for each resident at the end of each shift).

In relation to Mrs A's falls, the internal investigation report identified the following:

- All the falls occurred either on a weekend day or a public holiday, except for the fall at 6.50am on Friday 9 January 2009.
- All the falls were reported on an accident and incident form by the caregiver who found the resident.
- The documentation shows that Mrs A was examined by a registered nurse or a doctor after each fall and, on three occasions, this occurred on the day of the event. On one occasion (fall on 31 January 2009) this occurred on the following Monday. On the occasion of the last fall, the doctor's visit was at the request of the family.
- The findings of the follow-up examinations were documented at varying levels of detail.
- Except for the first fall, there is evidence that the family were notified of the incident on the day of the fall.

As a result of its findings, the rest home advised:

> "Review of the [p]olicy on Report Accidents and Incidents and the Falls Prevention Policy together with the reporting tools, has identified these documents

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

could be more explicit in detailing the required process, and documentation detail."

It also advised that it was implementing the following quality improvement measures:

- Clarification of when and who should communicate with families/whanau
- Clarification of the need to advise the Manager/RN "on call" of adverse events
- Revision of the accident and incident protocols
- Revision of the accident and incident reporting form
- Upskilling staff on accident and incident management
- Specific high risk falls assessment and management plan.

The rest home also acknowledged that Ms E's use of the RN communication book "appears to negate the need for reference to the resident's individual progress notes written each shift by the caregivers".

Further response and apology
The rest home advised HDC on 19 February 2010 that, with the assistance of Mr G, it had:

- reviewed its policies and procedures relating to the care, housekeeping, laundry and food services and established new manuals for each service. The care service manual includes policies, procedures, and guidelines for staff to assist them in meeting relevant standards
- developed ancilliary programmes on infection control
- revised its forms relating to management of clinical documentation (eg, pain management) to reflect current accepted practice and, where possible, best practice
- revised its handover practice. It now requires a handover report to be completed, and a verbal report to be given, for each resident, at the conclusion of each shift.

In response to criticism for failing to have nursing cover over the weekend period, the rest home advised that RN cover at the weekend was "idealisitic in the current funding formulas".

Enclosed with this advice from the rest home was a letter addressed to Mrs C, apologising "unreservedly" to her mother and the family for any distress caused over the care provided to Mrs A while a resident at the rest home. The apology was signed by Mr D and Ms F.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Dr J — meeting with family
On 7 May 2009, Mrs A's family (supported by a Health and Disability advocate) met with Dr J to discuss the care she provided Mrs A on 21 February 2009. The advocate advised HDC that at the meeting Dr J apologised to the family and advised that, in the future, she will not assume "what she is being told is the full story". At the conclusion of the meeting the family advised that they were happy with the outcome of the meeting and acknowledged that the issues stemmed largely from the rest home.

Code of Health and Disability Services Consumers' Rights & other relevant standards

The relevant rights in the Code of Health and Disability Services Consumers' Rights (the Code) are attached as **Appendix B**.

Opinion: Breach — Ms E

Management of Mrs A's pain
My expert advisor, Ms Spence, has praised the caregivers at Norfolk Court for their "regular and descriptive reports [which] often 'painted a clear picture' of Mrs A's needs". However, she believes Ms E's failure to respond to these reports "demonstrated a serious lack of professional observation and clinical guidance".

For instance, she notes that "[w]hile the pain was variable … there were very few days during [Mrs A's] admission where caregivers were not reporting significant pain/soreness or sadness", yet Ms E did not offer Mrs A any alternative non-pharmaceutical options to treat her pain (eg, massage or body support and changing position) except for one occasion when Mrs A was provided with a wheat pack.

While the increased codeine dose appeared to improve Mrs A's quality of life for about four weeks in November 2008, Ms Spence considers "this was a very brief remission in a very long period where her pain was consistent and on occasions described as 'lots of pain', 'very sore', 'very painful', 'depressed and in pain', 'great deal of pain'".

As Ms Spence rightly points out:

> "Nurses are advocates for their clients' comfort [and] well-being and in their lack of response to [Mrs A's] pain and distress they failed miserably.
>
> …

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> [Mrs A's] pain management, while complex, can only be described as abysmal. No resident in a 2-month period should have more than 70 reports of pain without creative and insightful actions being taken to address her comfort and well-being."

Communication with the doctors
Despite Mrs A's progress notes indicating that chronic pain was an ongoing problem, there is no evidence that this was relayed to the doctors at the consultations in November through to January.

Ms Spence advises that a multidisciplinary approach in rest homes is very important as doctors usually visit only monthly or when required. They are therefore dependent on accurate reports from staff about residents' signs and symptoms.

As Ms Spence notes:

> "Had the nursing staff identified more clearly the extent of [Mrs A's] discomfort, [Dr I's] treatment of her may have been more proactive."

I agree with Ms Spence that the lack of nursing intervention by Ms E in relation to Mrs A's pain is of serious concern. It was Ms E's responsibility to review and action the caregivers' reports, to advocate for Mrs A and provide care and comfort. Ms E also had a responsibility to ensure the doctors were kept informed about Mrs A's pain levels, and her response to the current medication regime. In all of this she failed.

It is noted that Ms E did not attend any pain management courses while employed by the rest home but, as Ms Spence points out, "pain would have been addressed in [Ms E's] fairly recently completed Bachelor of Nursing programme".

Management of Mrs A's falls
After each of her first two falls, Mrs A was examined by an RN on the day of the fall and no serious injuries were detected. As Mrs A's third fall occurred on the weekend, she was not reviewed by an RN until two days after the fall. Again no serious injuries were detected. The rest home advised HDC that Mrs A's daughter, Mrs C, was informed about the falls on 9 January and 31 January (however, Mrs C disputes that she was advised about the fall on 9 January).

In the days following each of these falls there are numerous reports of Mrs A being in pain, refusing to walk and moving very slowly, and she is noted to have a swollen right ankle.

The caregiver on duty did not think it was necessary to call a doctor following Mrs A's fourth fall on Saturday 21 February 2009. However, at the family's insistence, Dr J was asked to review Mrs A. Dr J examined her while she lay in bed, and found no abnormalities. Dr J had been told that Mrs A could weight bear.

Over the next few days Mrs A refused to weight bear, had difficulty standing and mobilising, and her ankle was noted to be swollen. On 24 February, Mrs C raised with Ms E her concerns about her mother's ankle but Ms E did not do anything in response. On 26 February Mrs A was taken to the medical centre (it is unclear

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

whether Ms E or the family requested this) where an X-ray revealed that Mrs A had a fractured ankle (approximately one week old) and a fractured hip (several weeks old).

Ms Spence advised:

> "Registered Nurses and Caregivers with current first aid skill[s] should be able to assess a resident for injury and even if the initial assessment does not find anything seriously wrong, the Registered Nurse should be monitoring the resident on a daily basis and certainly following up the daily progress reports made by others."

It is noted that the caregivers reported descriptively and regularly about Mrs A's pain after each fall, and Ms Spence believes "there would have been a significant amount of verbal reporting about pain and loss of mobility over this period too". Yet, during the doctors' visits on 7 January 2009 and 20 January 2009, the doctor was not specifically alerted to Mrs A's pain and lack of mobility. A doctor was asked to examine Mrs A on 21 February (at the family's insistence) and no abnormalities were detected. By 24 February Ms E had requested that two caregivers provide Mrs A with care as she was "refusing to weight bear", and Mrs A's family had indicated to staff their concerns about Mrs A's ankle. Ms Spence also notes that Ms E seemed to "ignore" the "simplest test of lower limb injury" — not being able to mobilise and significant pain and swelling. Ms Spence advises that she has serious concerns about this "lack of insight".

I agree with Ms Spence that the follow-up care provided to Mrs A by Ms E after her falls was inadequate. While it is acknowledged that the rest home's falls policies and procedures did not provide appropriate guidance to Ms E in the management of falls (and this was compounded by the fact that Mrs A had great difficulty describing where her pain was), as Ms Spence notes, the clinical signs should have alerted Ms E to Mrs A's "significant problems". Her failure to provide appropriate follow-up care in these circumstances is of serious concern.

The rest home considers Ms Spence's advice (that, following a fall, the registered nurse should be monitoring a resident on a daily basis for any new abnormalities) to be "idealistic in the current funding formulas". I find this difficult to accept given that the primary role of the registered nurse in a rest home is to ensure appropriate clinical care is provided in a timely manner. It does not seem unreasonable to expect the registered nurse to carry out a daily check on residents who have recently suffered a fall, particularly in light of ongoing reports by caregivers of pain and difficulty mobilising.

Mrs A's falls risk assessments

Ms E was responsible for developing "comprehensive" care plans for the residents that reflected the residents' needs. The risk of Mrs A falling was not addressed in her initial care plan. While Ms E was not responsible for this care plan (as she was on maternity leave at the time), she was responsible for developing all subsequent care plans.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In Mrs A's second care plan, neither the mobility section, nor the falls risk assessment was completed. In fact, it was more than five months before Mrs A's falls risk was first assessed (this is particularly concerning in light of the fact that Mrs A had been identified as a falls risk by NASC prior to coming to the rest home). Her falls risk was assessed again on 19 January 2009. Both assessments found Mrs A to be at low risk of falls, yet, in the month preceding the last assessment, she had suffered two falls.

It is acknowledged that the rest home's policies and procedures failed to adequately guide Ms E in this respect — for instance, there was no reference to falls assessments in the care plan procedure, and the falls prevention policy did not mention a falls assessment. It also seems that the rest home's tools for assessing falls risk were inadequate. Nonetheless, as the primary registered nurse, it was remiss for Ms E to allow five months to pass by before Mrs A's falls risk was assessed, and another eighteen months before it was assessed again. This is particularly concerning in light of Mrs A's falls history.

Steps taken to reduce risk of falls
Falls among elderly people are common — approximately one-third of people 65 years and older living in the community, and more than half of those living in residential care facilities or nursing homes, fall every year. Furthermore, about half of those who fall, do so repeatedly.[15]

Although it is unrealistic to expect residential care to totally prevent falls, regular checks and other proactive measures can be taken. For instance, beds can be lowered to minimise the risk of injury; the resident can be moved to a room closer to the nurses' station for easier observation; bells should be in reach; footwear should be checked to ensure it is appropriate; the resident's room should be uncluttered; and the resident's armchair should be safe.

Ms Spence could find no documentation in Mrs A's notes of any of the aforementioned proactive measures being taken, nor is there any evidence that the reasons behind Mrs A's falls were analysed or investigated. Accordingly, I do not believe sufficient steps were taken by Ms E to reduce or prevent further falls.

Communication with Mrs A's family
I note that between December 2008 and January 2009 there were six documented occasions of contact between Mrs C and the rest home, three of which were when Mrs C took Mrs A for an outing. I also acknowledge that, as Ms Spence notes, there may have been more contact than this, as it is not usual or necessary to record every time a family member visits. Ms Spence also notes Ms E's comment that she spoke to family (usually Mrs C) when they visited, and that Mrs A's family were notified of three out of four of Mrs A's falls.

In contrast, Mrs C advises that she was notified of only two falls (31 January and 21 February 2009). It is not possible to know for certain whether Mrs C was informed

[15] Kannus P, Palvanen M, Niemi S, and Parkkari J, "Alarming Rise in the Number and Incidence of Fall-Induced Cervical Spine Injuries Among Older Adults", in *Journal of Gerontolgy*, (2007), vol. 62a, No.2, 180–183.

about the fall on 9 January 2009, as recorded in Mrs A's notes. However, if the documentation is inaccurate, then this is of concern.

Also concerning is Ms E's apparently dismissive reaction to Mrs C's concern about her mother's ankle. I agree with Ms Spence's comment that "communication with the family lacked some insight and responsiveness" and her advice that "clear guidelines must be developed to assist staff in appropriate communication with families …"

Documentation
Ms Spence observed that progress notes were written routinely only by caregivers, and they were conscientious about reporting Mrs A's condition and care each shift. Ms E did not write in Mrs A's progress notes, except to record doctors' visits and changes in medication.

Ms Spence also noted that, over a seven-week period (from 1 January 2009 to 21 February 2009) the RN Communication Book contained (in relation to Mrs A) only eight entries by caregivers and only three entries by RNs, and one was a tick to acknowledge a report. I agree with Ms Spence's comment that this is not an adequate level of documentation for an RN:

> "If this, and the few written notes in the progress notes highlighting doctors' visits, is the only progress documentation written by the Registered Nurse, documentation is totally inadequate. It is also possible that the Registered Nurse was not reading the caregivers' progress notes and was dependent on the notes in the Registered Nurse Communication Book."

Ms Spence advised:

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

Summary

Ms E was responsible for ensuring Mrs A received appropriate and timely clinical care, and that this was delivered with reasonable care and skill. However, on a number of occasions Mrs A's needs were not adequately attended to. Ms E failed to respond to Mrs A's ongoing pain — she did not always convey Mrs A's pain and response to

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

medication to the doctors, and she did not attempt to introduce any pain management measures herself. Ms E's management of Mrs A's falls was also inadequate. She did not provide appropriate follow-up care, and she failed to take proactive steps to reduce the risk of falls, including adequate and timely falls risk assessments.

Ms E's documentation was also well below the expected standard, and her use of the RN communication book was inappropriate.

I acknowledge that Ms E was working under difficult conditions. She was very junior, with no experience in geriatric care, yet she was appointed to the position of "leader" RN, with a heavy workload and little clinical support. She was provided with little additional RN cover to enable her to complete her work to a satisfactory standard, despite requesting assistance; and the rest home's policies and procedures were often deficient and lacking in detail, providing her with little guidance or support.

Nonetheless, Ms E must take some responsibility for her actions and omissions. I conclude that Ms E failed to provide services of an appropriate standard with reasonable care and skill and breached Rights 4(1) and 4(2) of the Code.

Opinion: Breach — Ms F

Delivery of services and organisational management

Ms F has the overall responsibility of ensuring that the services delivered to the residents by the rest home comply with relevant standards, in particular the Code of Health and Disability Services Consumers' Rights, and the Health and Disability Services Standards 2001.

While I acknowledge that Ms F also lacked relevant experience and was insufficiently supported (discussed later), I consider that she too must bear some responsibility for the failings in Mrs A's care. It is clear from the number of departures from the relevant standards that Ms F was not adequately supporting staff and overseeing the delivery of services. It does not appear that she took steps to address Ms E's poor standard of documentation, the failure to carry out necessary assessments, or the poor management of Mrs A's pain and falls.

Ms F's lack of nursing knowledge may have made it more difficult for her to accurately monitor and assess the quality of the services being delivered. Ms F was clearly aware of her need to educate herself further, and took appropriate steps in this regard. As Ms Spence notes, Ms F chose some relevant courses, and had requested on a number of occasions (although this was always denied) that she be granted permission to attend the monthly management meetings held by Healthcare Providers NZ.

Nevertheless, despite her "best attempts" to educate herself for the position, and having a "sincere wish to lead her staff and care for the residents of Norfolk Court",

HDC

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms F failed to adequately monitor the delivery of services at the rest home and ensure Mrs A received an appropriate standard of care.

Accordingly, I conclude that she breached Rights 4(2) and 4(4) of the Code by: failing to ensure the services provided complied with relevant standards; and failing to ensure that the services provided minimised the potential harm to Mrs A or optimised her quality of life.

Opinion: Breach — Norfolk Court Rest Home Ltd

Mrs A had the right to expect that Norfolk Court Rest Home Ltd and its staff would provide reasonable care, respond appropriately to her pain, manage her falls risk and follow up appropriately. This was not the case, and Norfolk Court Rest Home Ltd must take primary responsibility for this for the following reasons.

Pain management

Mrs A suffered chest and back pain and, over a period of five months from 31 August 2008 to January 2009, there were frequent reports in Mrs A's progress notes of complaints of pain. Mrs A was initially given paracetamol for the pain, and regular codeine was added to this regime following consultation with Dr I on 16 September 2008. Mrs A was reviewed by Dr I on 14 October 2008 and he restarted her on codeine (15mg). Mrs A saw Dr I again on 4 November 2008 in relation to ongoing pain, and Dr I increased the dosage of codeine (30mg, four times a day) and paracetamol (1g, four times a day).

During the relevant period there was only one documented attempt by the rest home to relieve Mrs A's pain through an alternative means. This was on 18 September 2008, when she was given a wheat bag for her sore back. Both my expert advisor and the rest home's own investigation have highlighted the lack of non-pharmaceutical intervention.

It is acknowledged that Ms E was the person responsible for assessing and managing Mrs A's pain (and this has been discussed). However, in order for this to be achieved to an adequate standard, the rest home is responsible for providing policies and procedures to guide and support the registered nurse in the assessment and management of pain, and monitoring staff compliance with those policies and procedures. I agree with Ms Spence's comment:

> "Staff can not be expected to implement high standards of care without robust policies and procedures, education and supervision."

Ms Spence has described Mrs A's pain management as "abysmal". She regards the rest home's Pain Management Policy as "very superficial" and requiring "significant review".

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms Spence suggested the following be included in the policy:

- How pain is assessed
- How the pain management programme is planned
- Definition and management of acute and chronic pain
- Pain monitoring and use of pain scales to assess pain
- Use of the analgesics in the pain ladder
- Use of complimentary medication
- Use of alternative therapies, eg, massage, heat, relaxation, acupuncture

Ms Spence was critical of the lack of pain management tools used by the rest home to assess and manage residents' pain, and advised that "a specific care plan for pain management is essential". While a short-term care plan was written for Mrs A, this provided only for the administration of analgesia as a solution for her pain.

Ms Spence advised that a pain assessment should form part of a "holistic individualised assessment", which, if properly implemented "would have improved the safety and comfort of Mrs A's rest home experience". Ms Spence noted that "[e]xcellent [p]ain [a]ssessment tools are available and there is a plethora of research based nursing articles on the management of pain".

It is clear that the rest home offered insufficient guidance to Ms E, and this impacted on her ability to adequately assess and manage Mrs A's pain. I agree with Ms Spence's suggestions which, if included in the rest home's policy, will greatly assist staff in the management of residents' pain.

As noted earlier, the rest home has acknowledged a number of deficiencies in its pain management processes following its internal investigation, and it has revised its policies in light of its findings, including the introduction of a specific care plan for pain management. It is reassuring to note that Ms Spence considers these changes "will help ensure current and future residents will live their lives in much more comfort".

Assessment on admission, care plans, and falls policies
Norfolk Court staff also needed clear guidance for assessing residents such as Mrs A, for planning their care and preventing and managing falls.

Ms Spence advised that, at the time of these events, the rest home's policies and procedures relating to the assessment of residents, formation of care plans, and falls were insufficient.

Ms Spence refers to the goal contained in the rest home's procedure for care plans, which states that:

> "Norfolk Court Rest Home is committed to providing high quality care planning, to be able to maintain competent care to meet the individual needs of all Residents."

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I agree with Ms Spence that, while the goal is commendable, it is let down by superficial statements about how it will be achieved. There is no information about who will collect the residents' data; how that data will be collected; from whom the data will be collected; how the data will be recorded and within what timeframes; and how often the data will be reviewed.

Ms Spence also notes that there is "only a very brief statement about assessment which suggests taking vital signs". No reference is made to falls, pain, or pressure risk assessments. Nor is there any reference to the report from NASC, or to the transfer note from the discharging hospital. This information is "essential" to enable the rest home to assess the resident accurately and develop a corresponding care plan.

Ms Spence is also critical of the rest home's policies and procedures for assessing residents' falls risks. She notes that there is no reference to falls assessments in the care plan procedure, and the falls prevention policy "provides superficial guidelines". For instance, the policy does not mention a falls assessment "which is important to determine the resident's falls risk and, if the risk exists, a management plan to reduce the risk of falls".

Ms Spence also notes that the policy does not contain the procedures to follow in the event of a fall, such as assessment; guidelines for calling a doctor; treatment; documentation (accident and incident form and progress notes); advising next of kin; and accident and incident follow-up procedure. There are also no guidelines for minimising falls and management of residents who are having frequent falls.

Likewise, Ms Spence considers the rest home's accident and incident form is "barely sufficient". For instance, it does not advise staff to telephone a doctor if necessary, or to inform the resident's Enduring Power of Attorney or nominated contact person. There is no follow-up component (ie, investigation by an RN or Manager to identify hazards or causative factors of the accident or incident) and no requirement for staff to consider and record what corrective/preventative steps can be taken.

Commonsense dictates that if a resident is falling, particularly if it is more than once, prompt action must be taken not only to ensure the resident is unharmed or appropriately treated, but also to reduce the risk of it happening again.

It is clear that the rest home's staff were inadequately supported to accurately assess Mrs A's falls risk, and provide appropriate follow-up care (including introducing appropriate measures to reduce her falls risk after her first and subsequent falls). Mrs A's falls risk was not addressed in her first two care plans (she had resided at the rest home for more than five months before her falls risk was first assessed). This was despite the fact that Mrs A had been identified as a falls risk by NASC prior to arriving at the rest home.

Employee support — registered nurse

When Ms E was appointed by the rest home to the position of "leader" registered nurse, she was a new graduate and her only postgraduate experience was in paediatrics.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms E's position required significant education, experience and skill and, in order to succeed, she needed significant peer support from a qualified Manager or a contracted professional. She also needed sufficient RN cover to allow her time away from her clinical duties to complete the significant documentation required of her.

However, Ms E was not provided with any senior mentoring or clinical support. The manager had no nursing qualifications and, although another registered nurse was appointed on a part-time basis, he would look to Ms E for guidance.

While it is acknowledged that Ms E received some support from the rest home, by way of further education, this was clearly inadequate for someone so recently qualified and inexperienced. As Ms Spence notes:

> "[Ms E's] needs were so great she continued to struggle to provide leadership to the caregivers, maintain the documentation and more importantly provide the nursing necessary for the safety and comfort of the residents."

Following receipt of the complaint and the subsequent internal investigation, Ms E was provided with professional mentoring, which she found to be very helpful. It is concerning that the rest home failed to recognise this need earlier, and I note Ms Spence's comment that, had Ms E received professional help earlier she may well have succeeded in her role.

As Ms Spence advised, rest home owners have a responsibility to "ensure the registered nurses they appoint have the experience and skill to perform safely and, if in doubt, should ensure appropriate education and support is provided for them".

It is clear that Norfolk Court Rest Home failed to meet its responsibilities in this respect. Ms E was appointed to a position beyond her level of skill and experience, and the support she received from her employers was woefully inadequate to ensure she was equipped to provide services to a safe and appropriate standard.

I also consider that Ms E's orientation was seriously lacking. It consisted of four hours on her first day with another RN who was working at the rest home one day per week, and her "orientation checklist" was only partly completed.

As Ms Spence advised:

> " … RN [Ms E] may well have tried to be familiar with the policies and procedures but pressure of work and inexperience may have affected her ability to implement them.
>
> …
>
> Regretfully the lack of a sound orientation, reasonable workload and a lack of professional support did not support success."

Ms Spence identified a number of wider deficiencies with the rest home's staff orientation policy. For instance, she believes one hour is insufficient time to cover and

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

absorb all the information contained in the initial part of the orientation. She also believes that, while the policy mentions "familiarisation of all policies and procedures", it should identify the "essential ones which need addressing early" (eg, medication, infection control, personal hygiene, transferring and handling, food hygiene, and restraint).

Ms Spence noted that no timeframes are given with regard to completion of the "orientation checklist" or the second part of the orientation (covering caregiving and written aspects of the position). She advised that "[a] timeframe for a well planned orientation could last for up to [six] weeks with the topics to be covered each week identified".

Ms Spence has noted that the policy seems to be directed at caregiving staff (although there is brief mention of cooks, cleaners and laundry staff); there is no mention of a specific orientation programme for registered/enrolled nurses; and the differing orientation needs of staff (ie, those with or without previous education) have not been addressed.

I agree with Ms Spence that, while there has been "an attempt to provide a policy to orientate new staff", the policy is "light in content". The policy requires significant development to ensure that all staff receive the introductory training they need.

Employee support — manager
Rest home managers are required to hold a "current qualification or [have] experience relevant to both management and the health and personal care of older people".[16] While the type of qualification is not specified, I note that Ms Spence considers that it should be a qualification in nursing.

Ms F was appointed to the position of manager in 2002. She previously held an administrator position at the rest home. She held no management or nursing qualification and, other than completing the Aged Care Education Core Programme the year prior to her appointment, she had no experience in the personal care of older people. I accept that Ms F did not have to be an RN. Nonetheless I am concerned about whether Ms F's background and experience were sufficient for the demands of her role, and whether she received appropriate support, particularly in a situation where the primary RN had so little nursing experience. As Ms Spence notes:

> "Experience required in the position description suggests the Manager should have experience in Management, Employment Relations and Human Resource Development, Personnel Practice and Management of Organisations.
>
> While much of this knowledge may have been gained while working at Norfolk Court, it is risky for the owners/management team to employ the leader of their team to 'learn on the job'."

[16] Clause D17.3 (d) of the National Contract for Age Related Residential Care Services Agreement between District Health Boards and aged residential care providers.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Facility owners have a responsibility to ensure the facility is in safe professional hands, part of which involves providing staff with appropriate educational and training opportunities. The rest home denied Ms F's requests to attend the monthly management meetings, but, as Ms Spence notes, "[t]hese opportunities would have helped her greatly with her role identifying current issues in the rest home industry …". I also note that there is no mention in the manager's job description about compliance with the Health and Disability Services Standards; and no evidence that Ms F was given the opportunity to attend courses relating to these.

While recognising that Ms F did not need to be a nurse, I agree with Ms Spence that the rest home should have recognised Ms F's lack of relevant education and skills for the extent and challenges of her current role, and the consequent inability for her to perform her duties to the required standard without significant support. The rest home must therefore take significant responsibility for Ms F's omissions, in light of the failure to recognise and address the challenges Ms F faced owing to her lack of education and experience for the role.

Staffing levels
The level of clinical support at the rest home has been severely limited. All of the clinical responsibility for the complex health needs of the rest home's residents was left largely with one new graduate nurse and a visiting doctor. As Ms Spence advised:

> "Staffing levels should … reflect the need and level of care required by the residents and no staff member should be under so much pressure of work that they can not implement care kindly and safely.
>
> …
>
> Serious consideration should be given to standards relating to nurse ratios and qualifications of nurses in these positions. The work is challenging, diverse and extremely busy as the complex and increasing needs of older people are attempted to be met."

There was no RN cover at the rest home over the weekend period. While there is no formal requirement for rest homes to have an RN on duty at weekends, it is alarming that residents in a facility of this size (and including dementia patients) do not have this cover. Ms Spence has commented that, in order to provide a safe environment for the complex and varied needs of residents in this rest home, having weekend RN cover would be a "necessity". The rest home has advised that it is financially unrealistic. In that case, the rest home needs to ensure it provides its caregivers with very clear guidelines on seeking medical assistance when there is no RN on duty. These guidelines should provide a low threshold for seeking medical assistance.

Consultation and communication with family
Ms Spence also noted that there was no family meeting recorded for Mrs A in the two years she resided at the rest home. I agree with Ms Spence's observation that, had there been, many issues may have been resolved and the genuine and ongoing concern expressed by the family about Mrs A's pain may have had a much better outcome.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Accordingly, I agree with Ms Spence's recommendation that the rest home introduce regular multidisciplinary family meetings.

Forms generally
Ms Spence is critical of the forms used by the rest home:

> "Many forms are not well headed, some had no provision for the resident's name or for the staff completing them or making provision for signature and date.
>
> Some forms require an indication as to their purpose e.g. Short Term Care Plan — when they should be used and how they link to the Long Term Care Plan. They require a time frame and evaluation column and as earlier mentioned, date and signature columns."

I agree with Ms Spence's observation that the rest home's documentation, forms, policies, and procedures that were reviewed in relation to this investigation require significant development. I also agree with Ms Spence that the rest home should engage a consultant to carry out this work (with input from the RN), as the current manager does not have the necessary skills to do this without professional support, and the RNs do not have sufficient time.

Communication during scabies outbreak
It is accepted that the outbreak of scabies at the rest home was not confirmed until after Mrs A had been transferred to the public hospital, and this may have accounted for the failure to alert the public hospital of the outbreak. Nonetheless, the rest home may wish to consider amending its current Infection Control policy to remind staff about reporting infectious outbreaks to other facilities.

Summary

Following its internal investigation into the complaint about Mrs A's care, the rest home identified a number of gaps in its policies and procedures and advised HDC of the steps it was taking to address these, including: revision of the Accident and Incident reporting form; introduction of a specific high risk falls assessment and falls management plan; revision of its protocols for the management of accidents and incidents; upskilling staff on accident and incident reporting; and introduction of a specific care plan for pain management. These changes must be acknowledged and certainly seem overdue.

It must also be acknowledged that the rest home's policies and procedures (which my expert has criticised) apparently met the requirements of HealthCERT's auditing agency following the last audit before the complaints were made. However, it is important to note that the auditors assess the policies and procedures against a different and narrower set of criteria to HDC.

The purpose of the audit is to ensure that the rest home's policies and procedures meet the criteria set out in the Health and Disability Services Standards. My concern, and that of the expert advisor, is broader. We are concerned not only with whether the policies meet relevant standards, but also whether they comply with the Code and

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

have provided sufficient guidance to staff to enable them to provide an appropriate standard of care in this case.

In my view, the policies and procedures at this rest home did not provide an adequate safety net for Mrs A.

Norfolk Court failed to provide thorough, accurate and up-to-date policies and procedures; it appointed staff to positions beyond their level of experience and skill without providing adequate support to ensure safe practice; and it failed to provide the new RN with an adequate orientation to the role, policies and procedures.

The rest home's failure to adequately support and guide its staff in this way meant that the services provided to Mrs A were not of an appropriate standard, and it breached Rights 4(1), 4(2), and 4(4) of the Code by: failing to ensure services were provided with reasonable care and skill; failing to ensure services provided complied with the relevant standards; and failing to ensure the services provided minimised the potential harm to Mrs A or optimised her quality of life.

I am of the view that the breaches are of a seriousness that warrant the referral of Norfolk Court Rest Home Ltd to the Director of Proceedings.

Other matters

The investigation focused on the care provided to Mrs A by Norfolk Court Rest Home Ltd and its staff. The general practitioners were not investigated. This was because:

1. The care provided to Mrs A on 21 February 2009 by Dr J was the focus of a meeting on 7 May 2009 with advocacy support, and matters were appropriately resolved.

2. During the investigation minor issues in relation to Dr I's documentation and practice were highlighted. These were a failure to chart paracetamol and codeine as regular medications (although verbal instructions were given and recorded in the notes), and a lack of a structured recorded review process to assess the effectiveness of the analgaesia. However, these were apparently affected by the systemic problems at the rest home. The issues were followed up with Dr I.

Recommendations

I am satisfied that the initiatives introduced by the rest home following its internal investigation into the complaint adequately address many of the issues except for two areas.

I recommend that Norfolk Court Rest Home Ltd:

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- ensure it provides its caregiving staff with very clear guidelines on seeking medical assistance in the event an RN is not on duty or on call. These guidelines should provide for a very low threshold for seeking medical assistance.
- arrange for staff to attend courses on communication skills.

The rest home is to report back to me by **30 April 2010**, providing evidence of the steps taken to implement the above recommendations.

I recommend that Ms E also provide a written apology for her breach of the Code. The apology is to be sent to HDC by **30 April 2010** to be forwarded to Mrs A's family.

Follow-up actions

- Norfolk Court Rest Home Ltd will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the DHB, the Ministry of Health, and the Nursing Council of New Zealand with a recommendation that it consider whether a review of Ms E's competence is warranted.

- A copy of this report, with details identifying the parties removed except Norfolk Court Rest Home and the name of the expert who advised on this case, will be sent to the New Zealand Aged Care Association, the New Zealand Nurses Organisation, and the College of Nurses Aotearoa (NZ) Inc for educational purposes.

- A copy of this report, with details identifying the parties removed except the name of the expert who advised on this case and Norfolk Court Rest Home, will be sent to the medical centre and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A — Independent nursing advice

The following expert advice was obtained from registered nurse Lesley Spence:

"My name is Lesley Wynne Spence and I have been asked to provide nursing advice to the Commissioner on case number 09/00987.

I have read carefully the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Qualifications and Experience
I am a registered general and obstetric nurse (1963) and hold an Advanced Diploma of Nursing (1981, Distinction) specializing in medical nursing. My Practising Certificate No. 019220 is current.

Following graduation I worked in an acute medical surgical hospital becoming a staff nurse in a medical ward and prior to being promoted to a nurse tutor position was Sister-in-Charge of Christchurch Hospital on night duty (600 patients).

I taught General Nursing for 3 years (1966-1969) and then had a period raising a family during which time I worked part-time in a hospital for the aged.

In 1975, I was invited to teach in the then quite new Comprehensive Nursing programme at Christchurch Polytechnic where I was employed for 18 years.

During these years, I taught most comprehensive nursing courses but in the latter 5 years, I had the responsibility for post-graduate short courses which included courses in Gerontology (care of the aged). It was the importance of this knowledge that led me to accept the offer of a nurse manager's position in a large modern rest home caring for approximately 80 seniors. There I began to apply my learning to practice — I found it rewarding to be able to teach Registered Nurses and caregiving staff and see the benefits of their knowledge conveyed to the residents. I also developed skills in management which assisted in meeting the challenges of running a rest home.

From this rest home I was invited by new employers to develop a 60 bed rest home, Middlepark Senior Care Centre, from the building plans up — this gave me the opportunity to modify design, plan appropriate furniture, furnishing and equipment, write the policies and procedures, employ, orientate and educate the staff and develop trusting relationships with the residents.

While challenging, this project was enormously satisfying as I was able to implement the nursing philosophies I believed in.

Since then a further 2 rest homes, The Oaks Senior Care Centre (150 residents) and Palm Grove Senior Care Centre (118 residents) have been built to include long-term hospitals. Palm Grove was opened in December 2003.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

During that time my role changed to Principal Nurse Manager with oversight of the 3 centres.

In December 2007 I resigned from the position as Nurse Manager of Palm Grove Senior Care Centre. I am now working part-time for Christchurch Polytechnic, HealthCare Providers New Zealand and as an advisor to Christchurch Rest Homes.

I have recently helped set up an 18 bed hospital wing which is attached to a medium sized rest home. This involved helping with the design, purchasing all the equipment, employing and orientating staff to the new hospital policies and procedures.

I am a member of HealthCare Providers NZ (Canterbury Branch Executive Member).

I have facilitated a group of nurse managers to meet regularly in order to seek solutions to the serious shortage of registered nurses and caregivers in Canterbury.

I act as an advisor for:

- Christchurch Polytechnic Institute of Technology Post Graduate Courses for Nurses
- Health & Disability Commissioner
- Health Education Trust with input into the Aged Care Education courses for caregivers.

I regularly attend courses associated with the care of seniors in rest home and hospital facilities.

Palm Grove Senior Care Centre was chosen by the Ministry of Health to provide education for Bachelor of Nursing students, Nurse Assistants and Return to Nursing courses for Registered Nurses who wish to return to the workforce.

Expert Advice Required

I have been asked by the Health & Disability Commissioner to provide independent expert advice about whether Norfolk Court Rest Home provided an appropriate standard of care to [Mrs A].

[At this point in her advice Ms Spence sets out the background facts to the complaint and the questions asked of her. This information has been omitted for the purpose of brevity].

My comments on the appropriateness of care provided for [Mrs A] follow:

1. **Please comment generally on the standard of care provided by each of the following, in relation to their individual roles and responsibilities:**

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

a. Norfolk Court Rest Home Limited
b. [Ms E]
c. [Ms F]

I have made more in depth comments about the above in the report. In my opinion, however:

Norfolk Court Rest Home did not meet its legislative obligations or duty of care and the issues surrounding these have been more fully responded to in the report.

[Ms E] was appointed to a position beyond her level of experience and, considering she was working without more senior professional mentoring and support, she was seriously challenged to practice safely.

[Ms F] had a sincere wish to lead her staff and care for the residents of Norfolk Court well but did not have the professional educational background to succeed.

2. **Norfolk Court Rest Home Limited**

a. Comment on the adequacies of its systems and policies in relation to:

(i) *Assessment of Resident on Admission*
I could find no policy regarding resident assessment on admission but a form providing guidelines on Resident's Admission was included.

This provides brief but relevant notes for the admitting staff member.

There is however only a very brief statement about assessment which suggests taking vital signs — it does also state the nurse should refer to 'Admittance Forms'. No reference is made to the important support needs assessment which is provided by the DHB, or the transfer note from the discharging hospital. This is the essential information upon which the rest home assessment is made and the corresponding care plan can be developed.

While the Norfolk Home Guidelines may keep the resident safe for a short period, it is very superficial in content.

A care plan procedure has been provided with the goal that Norfolk Court Rest Home is committed to providing high quality care plans to be able to maintain competent care to meet the individual needs of all residents.

The goal is commendable but let down by superficial statements about how it will be achieved.

The only reference to assessment is:

- gathering information resident profile and history
- physical information and tests

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- nursing diagnoses

No information is provided as to:

- who will collect the data
- how and what data will be collected
- from whom the data will be collected
- how it will be recorded
- within what time frames
- how often the data will be reviewed

No reference is made to falls, pain or pressure risk assessments which should form part of a holistic individualised assessment and of course properly implemented would have improved the safety and comfort of [Mrs A's] rest home experience.

(ii) *Falls Prevention*
The falls prevention policy possibly written for caregivers provides superficial guidelines.

It does not mention a falls assessment — which is important to determine the residents falls risk and if the risk exists, a management plan to reduce the risk of falls.

No mention is made of the procedures to follow in the event of a fall:

- assessment
- guidelines for calling a Doctor
- treatment
- documentation (Accident Form), progress notes
- advising next of kin
- accident & incident follow up procedure

Some guideline for minimising falls should be included and also for management of residents having frequent falls.

Data should be collected from the Accident (Falls) form and referred to the Quality Improvement Committee for analysis and used as a basis for improving resident care.

Significantly more information is required in the Norfolk Court Falls Prevention policy to protect residents in their care.

(iii) *Outbreak Management*
General information is provided about:

- airborne microbes
- flu

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- MRSA
- Scabies

No information about the increasingly common norovirus. No mention is made of advising families, the wider community, public health agencies of an outbreak or the requirements for management of the outbreak in the facility.

Standard Universal Precautions are included and a brief policy on Infection Control. This does not mention the use of alcohol gels — a modern technique used in conjunction with correct hand washing to reduce the spread of infection.

The policy was last reviewed in 2007 yet it states that it should be reviewed annually.

The Universal Precautions have been taken from the Fundamentals of Nursing Textbook with no date included. They have not been reviewed since 2007. I would suggest a local source eg Infection Control Nurse from the rest home's laboratory tests provider would provide more up to date and relevant information.

The information about scabies is brief and does not include information about spread, treatment or prevention. There are no guidelines about advising families, staff or the wider community including hospitals if an infected resident is transferred.

In regard to [Mrs A], the caregivers did report on two occasions that she was itchy and applied creams.

In hospital she was diagnosed clinically of having scabies but skin scrapings were negative. She was, however, treated and so were staff attending her.

While policies guide actions, commonsense should have driven staff to advise other health facilities of the scabies outbreak.

(iv) *Consultation/Communication with families*
This policy identifies consultation and communication with families and significant others and recognises that this should be with the residents consent.

Appropriate circumstances for consultation are listed, however, an important omission is that of accidents and incidents.

Family meetings are suggested but no time frame is given. Ideally these should be 6-monthly at the time the care plan is reviewed to allow family participation.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

They may be formal or informal but must be documented.

No family meeting was recorded for [Mrs A] in the 2 years she resided at Norfolk Court; had there been, many issues may have been resolved and the genuine and ongoing concern expressed by the family about her pain may have had a much better outcome.

(v) *Accident & Incident Reporting*
The policy on Accident and Incident reporting is barely sufficient as it does not advise staff to call a doctor if necessary and to advise the family or next of kin.

Following completion of the report by the most senior person on duty and review by the Registered Nurse/Manager, the report should then form part of the data taken to the Quality Improvement Committee for review. The comments I have made about falls reporting also apply here.

(vi) *Reporting of Residents to Staff*
Handover — this appears to have been done via a handover book with notes written by the Registered Nurse.

It appears that the Registered Nurse notes took little cognizance of the progress notes written regularly by the caregivers (often each shift) hence details of [Mrs A's] health and well being were missed by the Registered Nurse.

I do not have a full copy of the Registered Nurse Communication book and of course it is not possible to know what verbal handover was given. However, I am very concerned about the quality of reporting to caregivers and other staff at handover times and consider the Registered Nurse's actions here were very remiss.

The Registered Nurse handover to Manager appears to have been verbal. The manager states in her report that many discussions took place to review [Mrs A's] care with the Registered Nurse and the doctor. This may have been effective but it has not been documented. It is usual practice in well run facilities to have a daily (brief) written report for the Manager which highlights changes or concerns about the residents.

(vii)*Pain Management*
This has been the biggest issue for [Mrs A] and her family.

When reviewing the Policy on Pain Management, many statements have not been implemented. I can find no reference to the Braden Scale for pain assessment being used, nor indeed a copy of the Braden Scale being completed.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The statement regarding Residents' pain being reported immediately to the Registered Nurse has been diligently followed by the caregivers in their progress reports.

However there was very poor follow up of the caregivers' observations and documentation of [Mrs A's] pain.

- No alterative non-analgesic suggestions for managing her pain were offered by the Registered Nurse eg massage, body support and changing position, heat in the form of a wheat pack.
- There were few reported responses to analgesia given and therefore the evidence to discuss with the Doctors on their visits was not available.
- The Resident Checklist on admission does not identify pain as a special need.
- I have very serious concerns about the management of [Mrs A's] pain.

(viii) *Doctors' visits to residents*

The issues with pain and oedema were addressed by the doctors on their visits over the period of concern but [Mrs A's] generally poor response to the analgesics charted did not seem to change their approach, either to investigate the pain further, or change the medication.

[Mrs A] was seen by:

19.09.08 [Dr I] — For chest pain and his assessment: unrecognised trauma — he charted Codeine and to review as required.

09.10.08 A chest X-ray was ordered and taken to investigate chest pain.

14.10.08 Following X-ray [Dr I] diagnosed osteomalacia, myalgia and restarted Codeine for the continuing chest pain.

04.11.08 As still sore in chest wall and back, varying locations, he treated [Mrs A] as having myalgia and increased Codeine and paracetamol and would review in 1–2 weeks.

18.11.08 Identified leg oedema and queried it to be secondary to hypoalbuminemia and ordered Ensure Plus to treat it.

25.11.08 Oedema still present and although stating [Mrs A] hated Ensure Plus, recommended it continue.

07.01.09 Noted [Mrs A] had not had Ensure Plus since mid-December and ordered that it start again as increasing leg pitting oedema. No calf tenderness or pain.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

20.01.09 [Doctor] — Noted only drinking one Ensure a day and requested it continue — stated less pitting in legs.

21.02.09 [Dr J] — An emergency after hours visit, she was asked to be seen by [Mrs A's] son who was concerned after he spoke to his mother on the telephone and she complained of pain. [Dr J] examined her in bed (because it was late) and because staff said she was weight bearing and that her right ankle was swollen and pink (long standing), she advised the [son's] family there was nothing serious.

On 26 February 2009, [Mrs A] was X-rayed and found to have a fractured right ankle.

[Dr J] wrote a full explanatory letter to Rae Lamb – Deputy Health & Disability Commissioner, and also arranged to meet with the family to explain her actions.

IN SUMMARY

I write this as a nurse commenting on doctors' actions which may not be appropriate.

Doctors' visits were regular and notes written appropriate to findings except on one occasion when the Codeine dose was changed and not charted.

The doctors appeared to generally assess [Mrs A] and responded to information from the nurses, however I do not think that [Mrs A's] pain was well investigated or treated. The medication was only partly effective and further investigation and alternative treatment methods could have been tried. A team approach with creative nursing interventions and or the use of a pain specialist could have been included.

b. The adequacy of support training/education provided or offered to [Ms E] by Norfolk Court/[Mr D] in light of her experience for the position.

The Registered Nurse appointed to the 'Leader' position required significant education, experience and skill. [Ms E], a new graduate, was very challenged by the role. She attended approximately 17 hours of appropriate education in 2007 and 24 hours in 2008. Much of this appeared to be supported by Norfolk Court. No pain management was included but many of the other sessions were relevant.

In March 2008 another Registered Nurse was appointed 2 days per week to help [Ms E] or to give her relief and/or allow her to catch up with her documentation, and this helped her for some time until this nurse resigned.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

While there was some support for [Ms E's] education from Norfolk Court/Mr D her needs were so great she continued to struggle to provide leadership to the caregivers, maintain the documentation and more importantly provide the nursing necessary for the safety and comfort of the residents.

[Ms E] has stated that the professional mentoring provided following these complaints has been a great help to her and it is of real concern that Norfolk Court did not see the need to provide her with this earlier when she became very stressed with her position.

In summary I believe that her experience, education, and support did not meet the significant demands and challenges of this position.

Her position was made even more difficult by the manager having no nursing qualifications.

c. The adequacy of the support/training/education/ provided or offered to [Ms F] by Norfolk Court/[Mr D] in light of her experience for the position.

[Mrs F] was appointed in 2002 and was approved by the Ministry of Health under the old licensing system.

No documentation of her orientation from her previous administrator position at Norfolk Court to Manager is known. Since then, she has achieved NZQA Standards:

2002: Manage acute cardiac events in ambulance services

Treat Hypovolaemic shock in ambulance services

2003: Workplace safety — ACC

2006: Use Standards to assess candidate for performance

2005: A 4-hour session provided by [the] DHB on Infection Control Pandemic Planning

Wound healing — prevention of pressure sores

Health & Safety — Employees responsibilities

Hazard Identification and hierarchy of controls

In service Education from 2001 consisted of 4-8 sessions a year for relevant Fire, Health & Safety and medical nursing topics.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Many of the topics in the last 2 years were taught by herself or the new graduate Registered Nurse. [Ms F] also completed the ACE Core programme and later the ACE Assessors Course.

She has also done courses in Food Safety, Team Building, Food Safety, Workplace and Management Practice, Risk Management, Restraint and Elder Abuse and Neglect. In September 2008 she completed an Internal Auditor Training Course.

There is no doubt [Ms F] has been aware of her need to educate herself to this important role and has chosen some relevant courses to do this. I do however have grave concerns about whether her early experience and education befits her for the modern facility/Nurse Manager position.

When checking her job description, I find no mention in the objectives to comply with the Health & Disability Standards. There is also no evidence she has been given the opportunity to attend courses relating to these.

Experience required in the position description, suggests the Manager should have experience in Management, Employment Relations and Human Resource Development, Personnel Practice and Management of Organisations.

While much of this knowledge may have been gained while working at Norfolk Court it is risky for the owners/management team to employ the leader of their team to 'learn on the job'.

I noted in [Ms F's] report her request to attend the [regional] Management meetings held monthly by HealthCare Providers NZ and that she would have liked to attend their conference. These opportunities would have helped her greatly with her role identifying current issues in the rest home industry and often providing training to address these. Recently there have been excellent courses relating to the 2009 changes to the Health & disability Standards which would be pivotal to her role.

d. The adequacy of handover/communication amongst staff members

It appears two methods of daily resident written reporting have been in use. The first is in the resident progress notes and another book (RN Communications Book) which was written in by the registered nurse to give new instructions to the caregivers and possibly a handover report.

It is of course not possible to assess the quality of the verbal handovers which may have been adequate but documentation either via care plan — short or long term, and progress notes was very inadequate. The registered nurse only recorded doctors' visits in progress notes.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I have reviewed a seven week summary of the Registered Nurse Communication Book which has highlighted some important issues. The dates covered were from 1 January 2009 to 21 February 2009. Over this period there were only eight entries by caregivers and only 3 by registered nurses; one was a tick to acknowledge a report. If this and the few written notes in the progress notes highlighting doctors visits is the only progress documentation written by the Registered Nurse, documentation is totally inadequate. It is also possible that the Registered Nurse was not reading the caregivers progress notes and was dependent on the notes in the Registered Nurse Communication Book.

e. The adequacy of documentation by staff generally.

Caregivers wrote careful and often insightful notes regularly but these notes were often not commented on or acted on by the Registered Nurse.

Care planning, both long and short term, was superficial and not sufficiently responsive to [Mrs A's] needs; the short term care plans did not indicate what their purpose was.

I note at the top of the progress notes, a daily care sheet is issued — none of these were included with the documentation provided. If they are used they may have given an overview of the daily care [Mrs A] received.

There was some inaccurate documentation of medication though these were not unduly serious.

A specific care plan for pain management is essential and I note it has now been introduced.

A specific care plan for wound care would also be required but this was not an issue for [Mrs A].

Generally all of the documentation, forms, policies and procedures require significant development and Norfolk Court Rest Home will require a skilled person to assist with this. I would recommend that a consultant be employed to do this work as the current manager does not have the background to write policy without professional support. Registered Nurses working in the facility would not have time free from the care of the residents to do this, although it would be important that they were included in the work in some way.

f. The adequacy of Incident/accident management and reporting

The four falls in the 'of concern' period were all documented by caregivers:

- 26 December 2008
- 9 January 2009
- 31 January 2009
- 21 February 2009

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Family were notified of the latter three.

The Registered Nurse checked [Mrs A] on 26 December 2008 and on 9 January 2009. Because it was the weekend, she followed up the fall of 31 January 2009 on the following Monday and documented her findings.

The fourth fall, on 21 February 2009 where it was likely [Mrs A] sustained the ankle fracture, the caregiver notified the daughter by answer phone message and documented her perception of the injuries in the progress notes saying that [Mrs A] did not want to get dressed, was resting on her bed and had swollen feet and legs and was in a lot of pain.

This was the time [Mrs A] should have been assessed by a Registered Nurse (weekend no RN on duty) or a doctor but the caregiver obviously did not see fit to ring for help.

In the afternoon, [Mrs A's] daughter [Mrs C's] husband rang to ask how [Mrs A] was and was told she was fine apart from a graze on her forearm. Later, [Mr B] (son) rang to ask how [Mrs A] was. He took the opportunity to let his wife ([Mrs B]) talk to his mother and later rang back to ask a doctor to visit his mother.

[Dr J] later visited — she noted the swelling in [Mrs A's] ankle but did not think it was fractured. She noted that she examined [Mrs A] in bed as it was her bed time.

She communicated her findings to the family shortly after the visit.

The progress notes continued on this date and 22 February 2009 noted that [Mrs A] was up three times during the night to the toilet and this morning OK.

From the morning of the 22 February 2009, however, there were consistent reports by the caregivers about pain when walking, but this pain and lack of mobility was not followed up until, on 26 February, an RN was asked to view the ankle and suggested an X-ray.

That afternoon an X-ray was performed and the fracture of tibia and fibula of the right leg was found.

While the responses to the pain and reduced mobility were poor, the recording of this incident was correct.

Incident & Accident documentation forms require a follow up component which includes investigation by Registered Nurse/Manager to identify:

- Causative factors eg hazards involved
- Corrective/preventative action determined and included in the care plan
- Additional policies developed
- Additional training needed

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Data from the monthly collating of accident and incident forms is referred to the Quality Improvement committee for follow up and benchmarking

g. The adequacy of the steps taken by Norfolk Court/Mr D to ensure:

(i) Its staff were adequately oriented/supervised/trained for their respective duties:

I have read the staff orientation policy which requires significant development, however the orientation checklist used for checking off the skills and knowledge required before staff commence their duties is comprehensive.

The checklist, which also includes the clinical component, states staff have three buddy shifts and it has a long checklist of items a new staff member must complete.

The checklist has a statement that the policy and procedure manual must be read immediately. This is ideal but could be challenging time wise for staff.

It is also important that the pain and medication policies in the manual are updated to use current knowledge.

Caregiving staff without Aged Care education should commence an approved programme as soon as possible.

Providing sufficient time is allowed for the orientation to be completed fully and signed off against the orientation checklist, staff could be safely orientated.

(ii) Its staff were adequately educated on clinical matters eg medication, pain management:

Existing staff have an in-service education programme with approximately 2 monthly education sessions which are relevant.

A number of caregivers have completed the Aged Care Education Core programmes which would provide them with good skills and knowledge for their roles.

Figures obtained from Ministry of Health's report show that of 20 care-giving staff, 9 hold accepted caregiving certificates, 10 are undertaking caregiving training and 1 has no qualification and is not seeking qualification (this is of concern).

The pain management policy provided for me is superficial and the medication policy requires some update. No mention is made specifically in the orientation checklist of these two important policies.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The Registered Nurse was required to read all policies prior to commencing and I am sure this would have had some effect on her performance. However she states her orientation was so short and she was learning alongside a nurse carrying out her daily duties that she would have had insufficient time to read policy and procedure.

I could find no mention of caregivers requiring medication competence, before being permitted to administer medications although mention was made in one instance of a caregiver having medication competence.

The pain management policy is very superficial, requires significant review with the following included;

- How pain is assessed
- How the pain management programme is planned
- Definitions and management of acute and chronic pain
- Pain monitoring and use of pain scales to asses pain
- Use of the analgesics in the pain ladder
- Use of complimentary medication
- Use of alternative therapies eg massage, heat, relaxation, acupuncture

Staff cannot be expected to implement high standards of care without robust polices and procedures, education and supervision.

Regular auditing of pain management will also identify areas of concern and support changes being made.

(iii) Its staff were following internal policies and procedures correctly:

Caregivers require the advice, supervision and role modelling from senior staff to implement policy. If the senior staff are not educated and supported to write and implement policy then there is a flow on effect for all staff members.

Some of the senior caregivers however demonstrated insight as they wrote in their reports and may also have been implementing knowledge from the Aged Care Education programme as a significant number had completed the core courses.

Registered Nurses and in particular RN [Ms E] may well have tried to be familiar with the policies and procedures but pressure of work and inexperience may have affected her ability to implement them.

Her orientation was also inadequate, superficial and in most facilities this is when new staff have time to concentrate on reading and learning policy and procedure.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

She talks about being overwhelmed by her workload and responded to this by asking for more RN support. Some time later a second RN was employed but only stayed 3 months and RN [Ms E] was again alone. She continued for a time then decided to hand in her resignation as she felt she could not carry out her duties safely.

At this time the CEO gave her a week's stress leave while they advertised for another RN. Eventually another RN was employed for 2 days per week to allow RN [Ms E] to catch up with paper work.

She had no mentoring until the Temporary Manager was instituted and she acknowledges that the help she has had since then has been of great support. Had she had professional help earlier she may well have succeeded in her role.

(iv) If Norfolk Court was meeting its various obligations under the code of Health & Disability Services Consumers' Rights and the Health & Disability Standards.

I consider that many of the 10 consumer rights were only partially met but the one of most concern was:

Right 4 – Proper Standards
Here [Mrs A] had the right to expect to be treated with proper care and skill and to receive services that reflected her needs. In her pain and accident management this was not achieved.

Health and Disability Standards 2001 (In place at the time of [Mrs A's] admission)

Organisational management

- The governing body did not ensure that services were well planned, coordinated and appropriate to the needs of [Mrs A]
- It did not appear to have a well functioning quality and risk management system
- The consumer information was not accurately recorded
- Adverse events were not systematically recorded or always reported to family
- The day to day service was not always managed in an effective manner which ensured the provision of appropriate and safe service to [Mrs A]
- The management of the service was not always effective and efficient and this too meant that [Mrs A] was not treated safely.

Governance
While I note that DHBs outline the qualities and experience they require of their managers in their agreements, the 2001 Health and Disability

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Standards state only that the organisation is managed by a suitably qualified and/or experienced person with authority, accountability and responsibility for the provision of services. This can be interpreted that no professional qualification is required. I believe there can be serious implications from this.

While [Ms F] appeared to have sincere motivation to provide good services to the residents of Norfolk Court, her lack of professional knowledge limited her ability to support and mentor her registered nurses.

Service delivery

- [Mrs A] did not always receive timely and safe service from qualified and experienced service providers
- Service delivery plans did not always meet the requirement of assessment planning and intervention
- Records did not always comply with regulatory requirements
- Consumers and communities were not always protected from preventable exposure to infection.

Regretfully Norfolk Court Rest Home was not meeting all of its obligations under the Health & Disability Services Act.

Registered Nurse [Ms E]

[Ms E] completed her Bachelor of Nursing in 2005 and registered as a Nurse in December 2005.

In January 2006 she commenced her new graduate programme at [a public] Hospital.

In July 2006 she was employed at Norfolk Court Rest Home as a Registered Nurse. Her orientation consisted of 4 hours on her first day with another Registered Nurse who was working at the rest home one day a week.

An orientation checklist was partly completed but has no name, date or signature. An O.S.H. and Employment Checklist was signed by [Ms E] but again, no date.

She worked 4 days per week until she went on maternity leave on the 10th November 2006 recommencing at Norfolk Court on 12th February 2007. At this time she was the sole Registered Nurse for the facility. She felt overwhelmed by this and requested the help of another Registered Nurse as she felt she could not carry out her duties effectively. Later that year a second Registered Nurse was employed to assist her while she caught up on care plans. This nurse stayed 3 months and then moved to [the main centre].

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

She again requested help and when it was not forthcoming, handed in her resignation as she could not carry out the duties required of her. The CEO then gave her one week's stress leave and advertised for another Registered Nurse for 2 days per week.

[Ms E] states she had no other clinical support and found she was the person the other Registered Nurse turned to for guidance. When the temporary manager was appointed she felt much more supported but has since resigned.

In the first year of her appointment, 2007, she had approximately 17 hours of relevant education. In 2008, 24 hours of appropriate education as well as 40 hours in the in-service education programme over 2 years, some of which she taught herself. She also completed some cultural and restraint training.

Generally the education offered to [Ms E] has been relevant and adequate. However, for a new graduate, her orientation was very limited and along with the lack of professional support did not set the scene for the responsibilities involved. She came to Norfolk Court as a new graduate, her only post-graduate experience was in paediatrics. To succeed, she needed significant peer support from a qualified Manager or a contracted professional. She also needed sufficient Registered Nurse staffing to allow her time from her clinical duties to complete the significant documentation required of her.

Regretfully the lack of a sound orientation, reasonable workload and a lack of professional support did not support success.

(1) *The adequacy of the steps taken to identify the risk of [Mrs A] falling*

Four care plans were written during [Mrs A's] stay at Norfolk Court Rest Home. In the first - 'the initial care plan' (no date), the risk of falling was not addressed and [Mrs A] was described as not requiring supervision or assistance with mobility.

The second care plan, 16th February 2007 – the mobility section has not been completed, nor has a falls risk assessment.

The third care plan, 25th June 2007 – following hospitalisation for a fracture, identified her need for a frame and assistance to mobilise. She was also provided with a monkey bar to assist her to move in bed. A Falls Risk Assessment was completed which identified [Mrs A] as low risk.

The fourth care plan, 26th July 2008, [Mrs A] was identified as needing assistance transferring and uses a walker when mobilising. It was also noted that she was sometimes unsteady on her feet.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Another Falls Risk Assessment was completed on 19th January 2009 which again showed [Mrs A] to be at low risk for falling yet by now she had had 2 falls.

The proactive planning to avoid the risk of [Mrs A] falling was inadequate.

(2) *The adequacy of the clinical assessment of [Mrs A] following each of her falls*

26/12/2008	[Mrs A] was checked by the RN who said she was fine.
09/01/2009	The fall was followed up by the RN who could find no abnormalities.
31/01/2009	Caregivers could find nothing of concern and the RN followed up after the weekend on 02/02/09 and could find nothing wrong.
21/02/2009	Caregivers again on duty who believed there was no serious injury. After discussions over the day with the family it was they who insisted a doctor was called. The doctor who examined [Mrs A] in bed also could not find any abnormality.

In regard to the fractures, while I cannot condone poor assessment, several staff and the Manager have stated that [Mrs A] had difficulty describing where her pain was, however, the clinical signs (swelling and difficulty and resistance to walking) should have alerted the senior staff to the significant problems. The caregivers reported descriptively and regularly about her pain after each fall, eg on 23rd February 2009, two days after her 4th fall: '[Mrs A] has great difficulty to stand and weight bear. Appears she has no strength to stand let alone walk. Transferred on and off toilet with great difficulty.'

By 24th February 2009 the RN had requested that 2 caregivers provide her care. She had Panadol at lunchtime but I can find no record of Codeine being administered on the 24th February 2009 although it was re-charted by the doctor on the non-regular drug orders on this date: 30mg per oral B.D.

Nursing staff did assess her after 3 of 4 falls and all found nothing serious wrong — yet the simplest test of lower limb injury of not being able to mobilise and her significant pain and swelling seemed to be ignored. I consider this lack of insight of serious concern.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In regard to steps taken to reduce the risk of her falling, she was provided with a frame in June 2008 and although caregivers reported consistently about her pain and difficulty walking they did not appear to have major difficulties caring for her until late February after her 4th fall when the RN did instigate 2 carers for transferring.

In terms of supervision, it is always difficult at rest home level of care to be able to observe residents at all times, however regular checks can be implemented. Beds can be lowered to minimise the risk of injury, the resident moved to a room nearer the nurses' station for easier observation. Bells should be within reach, Footwear appropriate. The room uncluttered. A safe armchair. If these measures are not being effective then the resident should be referred for further medical review and/or reassessment.

None of these measures were documented and I would consider therefore that there was insufficient proactive care to prevent [Mrs A] falling or to investigate the reasons why she was falling.

(3) *The appropriateness of the decisions not to seek further medical advice from the Doctor after each of [Mrs A's] falls*

Because falls in the elderly are common, it would not be possible to expect a doctor to assess every resident who falls. Registered Nurses and caregivers with current first aid skills should be able to assess a resident for injury and even if the initial assessment does not find anything seriously wrong, the Registered Nurse should be monitoring the resident on a daily basis and certainly following up the daily progress reports made by others.

In [Mrs A's] case there was clear progress reports written by caregivers about her pain. I am sure there would have been a significant amount of verbal reporting about pain and loss of mobility over this period too. The family also indicated their concern on a number of occasions. Doctors did visit on 7th January 2009 and 20th January 2009 but weren't specifically alerted to the pain and lack of mobility.

On 21st February 2009, Dr J was called by the insistence of the family but because [Mrs A] was in bed, did not find the fractures either.

Generally the follow up of the falls was poor, particularly on the last occasion but I do think staff found [Mrs A's] identification of where she felt pain confusing, sometimes her complaints of pain did not relate to her injury sites and also on some occasions she continued to mobilise without complaints of pain.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

(4) *The adequacy of the management of [Mrs A's] pain during the relevant period*

From 9th September 2008 — 26th November 2009 I counted more than 70 reports written by caregivers of [Mrs A] being in pain.

On 4th November 2008 the Codeine dose was changed (although not charted), [Mrs A] appeared to be more comfortable.

On 26th December 2008 [Mrs A] had the first of 4 falls over a 7 week period. She had consistent pain which she was not able to clearly identify but reduced her mobility significantly and often meant she required a wheelchair. At no time was a pain assessment done or a doctor called to specifically address the pain or mobility problems.

A short term care plan was written but was not clearly identified as a plan for pain and it only provided the administration of analgesia as a solution. Excellent pain assessment tools are available and there is a plethora of researched based nursing articles on the management of pain. RN [Ms E], in her continuum of learning while at Norfolk Court did not attend any specific pain management sessions or courses. However pain would have been addressed in her fairly recently completed Bachelor of Nursing programme.

While Panadol was administered regularly, a higher dose of Codeine appeared to improve [Mrs A's] quality of life for about 4 weeks in November 2008, but this was a very brief remission in a very long period where her pain was consistent and on occasions described as 'lots of pain', 'very sore', 'very painful', 'depressed and in pain', 'great deal of pain'.

Nurses are advocates for their clients comfort, wellbeing and in their lack of response to [Mrs A's] pain and distress they failed miserably. I view the lack of nursing intervention from the RN and Manager in relation to [Mrs A's] pain with serious concern.

(5) *The adequacy of incident reporting following [Mrs A's] falls*

This has been discussed earlier and has been found to be below standard.

(6) *The adequacy of communication/consultation with [Mrs A's] family during the relevant period*

I could find only 3 notations in the progress notes identifying that a member of the family had been notified about incidents or care.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The family were notified about 3 of the 4 falls, however, [Ms F] says she was present on numerous occasions when [Mrs A] was discussed by the doctor and RN who also mentions this in her account of evidence, but these discussions were not always documented. I also note that she tried to contact [Mrs A's] daughter about the X-ray but was unsuccessful, however her daughter arrived as the Manager was putting her in the car to take her to X-ray. RN [Ms E] also mentions she spoke to family (mostly [Mrs C]) when they visited.

While communication was not always documented, I believe the family was up to date with [Mrs A's] care.

(7) *The adequacy of communication with other staff regarding [Mrs A's] condition during the relevant period*

Progress notes were only routinely written in by caregivers and they were conscientious about reporting [Mrs A's] condition and care each shift.

[Ms E] only used progress notes for doctors visits and changes to medication. It appears the RN Communication Book was her preferred method of communication for any new interventions required.

Clearly documented communication was inadequate and unfortunately it is not possible to know the quality of daily verbal communication.

(8) *The standard of documentation during the relevant period*

The use of an RN Communication Book is unusual and certainly not a safe practice — many facilities do use a handover book which highlights special events eg Dr coming to see [Mrs A]; special dressing ordered for [Mrs B] will be delivered by … [Mr J] out until approx 10 p.m.

It should not be used as a method of conveying nursing intervention which is recorded in the nursing care plan and reinforced in the progress notes where necessary.

The short term care plans for pain, wounds, behaviour management etc require significant development.

Many forms are not well headed, some had no provision for the resident's name or for the staff completing them or making provision for signature and date.

Some forms require an indication as to their purpose eg Short Term Care Plan — when they should be used and how they link to the Long Term Care Plan. They require a time frame and evaluation column and as earlier mentioned, date and signature columns.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

While the Short Term Care Plan could be used for pain management, it is inadequate and a specific format should be devised. I note in Mr G's report this is being done.

Follow up from Incident & Accident reporting was inadequate. There was no evidence that these reports were collated and referred to the Quality Improvement Committee or Health & Safety Committee for follow up and benchmarking.

In regard to the documentation for [Mrs A] over the relevant period, my overall impression is that it was very inadequate for the following reasons:

- Poor reporting by RNs to caregiving staff in progress notes and care plans. I consider that RNs should be writing daily progress notes with follow up in the following shifts by caregivers when the residents condition changes or other events require documentation.
- Poor recording of follow up to relatives
- Poor recording of pain management
- Inadequate nutritional assessment
- Inadequate falls risk assessment and follow up

There were also errors in medication recording and the medication signing sheets had dates but no year.

It was pleasing to see the regular and descriptive reports by the caregivers. They often 'painted a clear picture' of [Mrs A's] needs. Unfortunately these consistent entries were not responded to by the nurses leading their teams.

[Ms F]

a. **Whether [Ms F] took sufficient steps to assure herself [Mrs A] was receiving appropriate care during the relevant period**

[Ms F] admitted she relied on the RN for clinical judgment as she was not a nurse. In a smaller rest home such as Norfolk Court, there has to be significant concern when one new graduate nurse and a visiting doctor carry all of the clinical responsibility for the complex health needs of the residents.

[Ms F] appears sincere in her account of the events that she believed she was working effectively in her role, however, despite her best attempts to educate herself to this responsible position, I have very serious concern that her educational background did not fit her for the manager's role.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

While recognising she was employed under earlier legislation — the owners (CEO) should have recognised her lack of skill for the extent and challenges of her current role. Many DHB agreements with rest homes now require that the rest home must engage a manager who is either a General Practitioner or a Registered Nurse with a current practising certificate.

It is a significant responsibility of owners to ensure that their certified facility is in safe professional hands and to provide support to ensure they succeed in providing safe and considered care.

b. **Are there any aspects of care provided by Norfolk Court, [Ms E] or [Ms F] that you consider warrants comment**

Whether [Ms F] took sufficient steps to ensure discussions and action around [Mrs A's] care were being documented accurately:

[Ms F] states she did discuss [Mrs A's] care on numerous occasions with the doctor and the RN, but these were not documented. Her lack of nursing knowledge may have made it difficult for her to assess the quality and accuracy of the documentation. If the audit programme was being carried out in accordance to the accepted Standards, she may have been able to respond to the outcomes of these, despite her lack of nursing knowledge.

It appears there is no registered nurse cover for the residents over the weekends. On checking the Norfolk Court rest home website I note that it provides 48 rest home beds and 11 beds for people with dementia.

I would consider this number of residents should not be left in the care of caregivers for weekends even if they have education and experience and had access to a nurse on call.

While there are no formal requirements at present for rest homes of this size to have a registered nurse on duty at weekends, in my opinion … in order to provide a safe environment for the complex and varied needs of residents in this rest home (which includes a dementia unit), a registered nurse over seven days would be a necessity.

A weekend registered nurse would continue to monitor residents well being, ensure rosters were filled, and caregivers were giving appropriate care. He/she would also maintain professional communication with families and visitors — a busy part of weekend work.

Caregiver judgement in regard to falls at Norfolk Court is an example of the need to have a skilled registered nurse readily accessible. Several of

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Mrs A's] falls occurred at weekends and were not followed up until Monday, if at all.

c. **The adequacy of [Ms F's] communication with [Mrs A]/her family and [the public] hospital regarding the scabies outbreak**

Neither the Infection Control Policy or Universal Precautions guided management require the RN to report this very infectious condition to other personnel or facilities. However, common sense should have been the trigger to advise others of the outbreak and alert them to the consequences.

While it was thought [Mrs A] was asymptomatic to scabies at the time of transfer to hospital, caregivers did report on two occasions that she was itchy. At [the public] Hospital her suspected scabies were treated for clinical reasons but pathological reports of scrapings did not confirm she had it.

It appears that the outbreak of scabies at Norfolk Court was not confirmed until after [Mrs A] was transferred to hospital which may have accounted for the break down in communication.

3. **The adequacy of information provided by Norfolk Court Rest Home to [Mrs A] and/or her enduring Power of Attorney ([Mrs C]) and or her family between December 2008 and January 2009**

There were approximately 6 recorded contacts with [Mrs C] during this time, 3 of which were when [Mrs C] took [Mrs A] for an outing. It is probably fair to assume there may have been more than this as it is not usual or necessary to record every time a family member visits.

Of concern, in a phone call to [the HDC investigator], [Mrs C] described how on one occasion the RN brushed her off when she was requesting that something needed to be done for her mother 'now'. The nurse said it was late in the day and she would need to speak to someone. Then her cell phone rang and she answered that.

She said she also found [Mr D] (CEO) very dismissive. When she approached him about her mother and her deteriorating health [Mr D] said 'most people just put them here and let us get on with it'. This interaction was superficial, dismissive and totally unprofessional.

However I do sense in [Ms F's] report there would have been many acts of kindness shown. [Ms E] also expresses her regret and concern for any distress caused.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Despite this I believe there was insufficient communication, some of it dismissive and some of it poor quality. Much has to be learned and acted upon by this facility in terms of professional and warm communication.

4. **The adequacy of information provided by [Ms F] to [Mrs A] and/or her Enduring Power of Attorney and/or her family between December 2008 and January 2009.**

   This has been covered above.

5. **The adequacy of the changes made by Norfolk Court since these events**

   Since the temporary manger has been in place the following has been implemented:

   - Professional mentoring for the manger and registered nurses
   - Enhanced handover reporting
   - Clarification of when and who should communicate with families
   - Clarification of advising the manger of adverse events
   - Revision of protocols and tools for the management of accidents and incidents
   - Safe medication management and pain management policies implemented
   - Up-skilling staff on pain management
   - Implementation of an auditable multi-disciplinary team review process
   - Review of the infection control programme
   - All of the above addresses the concerns that I have identified apart from the need to consider more professional supervision over weekends and some courses on communication skills could be helpful. Professional assistance for the upgrading of all policies and procedures and auditing requirements may also be needed.

6. **Are there any aspects of care provided by Norfolk Court, [Ms E] or [Ms F] that you consider warrants comment**

   Qualifications for Managers: In both the 2000/01 and the later additions to the Health and Disability Standards 2008 it is stated that managers for retirement facilities must be qualified/experienced. In the organisational management standard [it states] 'consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.'

   My interpretation of this is that the qualification should be in nursing preferably with some advanced nursing studies and the experience should include management and administration.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Facility owners should also ensure the registered nurses they appoint have the experience and skill to perform safely and if in doubt should ensure appropriate education and support is provided for them.

Staffing levels should also reflect the needs and level of care required by the residents and no staff member should be under so much pressure of work that they cannot implement care kindly and safely.

In my opinion a registered nurse should be employed on duty to cover weekends.

Orientation systems should be developed for all staff and audited to ensure that each staff member receives the introductory training they need.

Investigation into the workload of RNs in rest homes — many of whom alone have direct supervision and clinical care of 40+ residents.

Serious consideration should be given to standards relating to nurse ratios and qualifications of nurses in these positions. The work is challenging, diverse and extremely busy as the complex and increasing needs of older people are attempted to be met.

I have some empathy with the plight of [Ms E] — her responsibilities far outweighed her experience and skill; like many young nurses, she is working full-time with a young family, her workload appeared to be unrealistic and she had no mentoring to assist her with her responsibilities.

In summary and in my opinion, Norfolk Court Rest Home did not meet its legislative obligations or duty of care in the following:

- All staff require significant up-skilling in medication administration, accident and incident reporting and management, pain management, infection control, and communication.
- Clinical Governance — the selection and education of its manager did not enable her to perform her duties to the necessary standards and there appeared to be insufficient support and good role modelling by the owner [Mr D].
- The orientation, peer support and clinical guidance of its lead RN was also inadequate and the employment of a new graduate to this responsible position could be questioned.
- Communication with the family lacked some insight and responsiveness and the reported interaction with the CEO was completely unprofessional and devaluing of both [Mrs A] and her daughter. I believe clear guidelines must be developed to assist staff in appropriate communication with families, and regular multi-disciplinary family meetings instigated.
- Documentation in assessment, care planning, intervention and evaluation was inadequate and while reporting in the progress notes was done well by the caregivers it demonstrated a serious lack of professional observation and clinical guidance by the RNs.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Pain Management — [Mrs A's] pain management, while complex, can only be described as abysmal. No resident in a 2 month period should have more than 70 reports of pain without creative and insightful actions being taken to address her comfort and well-being.
- Overall I believe that Norfolk Court CEO [Mr D], [Ms F] and [Ms E] did not provide the standard of care [Mrs A] had the right to expect under the Health & Disability Act and I believe their peers would view their conduct with severe disapproval.

Lesley Spence
20 October 2009"

SUBSEQUENT ADVICE ABOUT ORIENTATION POLICY

"I have now been provided with the Norfolk Court orientation policy and have been asked whether I wish to review or change any of my initial advice re staff orientation.

Were Norfolk Court Staff adequately orientated/trained for their respective duties?

My comments in the initial advice were based on an orientation checklist included in the documents sent to me. This checklist is comprehensive and if implemented fully and checked off as required, would ensure that staff were safe to practice clinically.

However the checklists I reviewed were not completed fully.

Norfolk Court policy on orientation for new staff was reviewed annually from 1996 to 2004 and then to be reviewed as necessary.

The policy is general and mentions a 1 hour orientation programme to be undertaken in the new staff members own time.

During this hour staff will be familiarised with:

— The building
— Occupational Health & Safety routines
— Individual routines
— Policies and procedures

A checklist will be completed but no timeframe is given.

A further orientation to cover caregiving and written aspects of the positions will follow after orientation of the building. No timeframe is given.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Following this the new employee will be orientated in the general care of the elderly completing 2 to 3 shifts with a relevant buddy.

There is no statement identifying the differing orientation needs of staff with or without previous education.

An appraisal is carried out after 3 months by the Manager.

Comment:

This policy appears to apply mostly to caregiving staff although there is a brief mention of cooks, cleaner & laundry person.

There is no mention of an orientation programme for Registered Nurses/Enrolled Nurses.

There is no payment for orientation until after 6 months of continuous employment and while some facilities adopt this, it is harsh and does not engender warm relationships at the beginning of a new staff member's employment.

The initial orientation contains far more information that could ever be covered or absorbed in 1 hour.

While the policy mentions familiarisation of all policies and procedures it does not identify the essential ones which need addressing early for new employees eg medication, infection control, personal hygiene, transferring & handling, food hygiene, and restraint.

A statement needs to be included about how to access information.

A timeframe for a well planned orientation could last for up to 6 weeks with the topics to be covered each week identified.

The facility's organisational philosophy and mission statement should also be discussed along with the quality improvement programme.

IN SUMMARY

There is an attempt to provide a policy to orientate new staff, however it does not:

- address all staff needs
- provide a structured process for the content to be covered or the timeframe required
- allow sufficient time to ensure safe practice
- allow for caregivers varying levels of education, or identify the requirement for them to achieve an approved aged care education programme within a prescribed period
- encourage warm relationships as it withholds payment for the orientation period for 6 months

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I do note in the Ministry of Health audit report, significant numbers of caregivers have achieved their ACE Core Programme or were working towards it. Only 1 staff member at that time was not actively involved.

The manager [Ms F] is an ACE assessor and appears to have worked well with her staff to ensure they gained appropriate education. However the orientation policy is light in content and requires significant development. This may well have affected the performance of staff at Norfolk Court.

The Registered Nurse [Ms E] has stated her inadequate orientation affected her practice and stress levels.

While well written policies guide best practice, it is of course the implementation which counts. This is dependent on competent leadership, good role modelling a sound education policy and sufficient staff and time to perform best practice. Significant work is required by Norfolk Court owners and managers to achieve this.

Lesley Spence
22 November 2009”

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

Appendix B

Right 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Names have been removed (except Norfolk Court Rest Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.