Edmund Hillary Retirement Village

General Practitioner, Dr P

A Report by the

Acting Health and Disability Commissioner

Case 08HDC17309

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr A had lived at Edmund Hillary Retirement Village (the Village) since October 2007. He had previously been treated for prostate cancer. In December 2007, his PSA level was checked and general practitioner Dr P noted that Mr A should continue to have monthly PSA tests.[1] Dr P noted that if Mr A's PSA level rose above 10µg/L, treatment should be restarted. Mr A next had his PSA checked in February 2008, and then a few months later, by which time it had gone up to 38.8µg/L. Dr P arranged for Mr A to have a Lucrin injection, and this was administered the following month.[2]

A few days later, Mr A had a fall in the Village dining room. He was checked by nursing staff, who found no evidence of injury. Mr A's son, Mr C, was informed. He advised staff that his father's balance had been affected following previous Lucrin injections. At six o'clock the next morning, Mr A was found by a caregiver on the floor of his bathroom. He was checked by nursing staff and it was agreed Mr A should be seen by a doctor. By 8.30am, there was swelling and bruising around his left eye, and bruising to his right elbow and sides. Dr P saw Mr A at 1pm and identified some tenderness about the right side of the chest but no significant injury.

The following day, Dr P arrived at the Village at about 10am for his scheduled round and saw Mr A at about 2pm. Mr A's condition had deteriorated and it was agreed that he should be admitted to hospital. A routine request for ambulance transport was made, and the ambulance arrived at about 4pm. Mr A was admitted to hospital. He was found to have a fractured left eye socket and an odontoid peg fracture (part of the cervical spine). There was a possible fracture of the fusion between his 2nd and 3rd vertebrae although this may have been old. He was dehydrated.

Mr A died the next day. The cause of death was recorded as upper airway obstruction with a background of aspiration pneumonia, rib fractures and a C2 fracture.

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[1] A PSA test measures the level of a protein (Prostate-Specific Antigen) produced by the cells of the prostate gland. Prostate cancer can increase PSA levels, so the test is used to detect prostate cancer (although some men with prostate cancer have normal PSA results). The normal range for a man over 70 years is 0–6.5µg/L.

[2] Lucrin (leuprorelin) is a treatment for prostate cancer used to block the secretion of hormones that help cancer cells to grow. It is usually given in the form of a long-acting injection.

Complaint and investigation

On 20 October 2008 the Health and Disability Commissioner (HDC) received a complaint from Mr B on behalf of Mr A's family about the services provided by Edmund Hillary Retirement Village and Dr P. An investigation was commenced on 9 February 2009.[3]

The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Edmund Hillary Retirement Village in late 2008, including the adequacy of the documentation.*

- *The appropriateness of the care provided to Mr A by Dr P in 2007 and 2008, including the adequacy of the documentation.*

The parties directly involved in the investigation were:

Mr A	Consumer
Mr B	Complainant/Mr A's son
Mr C	Mr A's son
Ms D	Mr A's daughter
Edmund Hillary Retirement Village	Provider
Ms E	Care Assistant
Ms F	Enrolled Nurse
Ms G	Clinical Manager
Ms H	Care Assistant
Mr I	Registered Nurse
Ms J	Registered Nurse
Ms K	Enrolled Nurse
Ms L	Care Assistant
Ms M	Care Assistant
Mr N	Facility Manager
Ms O	Regional Manager
Dr P	Provider/GP

Also mentioned in this report:

Mr Q	Chief Executive Officer

Information was reviewed from: the family, Edmund Hillary Retirement Village, Dr P, the public hospital, the Ministry of Health, ACC, and St John Ambulance. Expert advice provided to Edmund Hillary Retirement Village by geriatrician Professor Tim Wilkinson and registered nurse Beverley Rayna was also reviewed.

Independent expert advice was obtained from registered nurse Wendy Rowe (attached as **Appendix A**) and general practitioner Dr Ngaire Kerse (attached as **Appendix B**). Preliminary advice had been obtained prior to the start of the

[3] The District Health Board and the Ministry of Health received complaints at the same time as HDC, and the three agencies consulted to avoid duplicate, simultaneous inquiries.

investigation from registered nurse Jenny Baker, Dr Ngaire Kerse, and from HDC's clinical advisor, Dr David Maplesden.[4]

Information gathered during investigation

Background

Mr A (aged 80 years) was admitted to Edmund Hillary Retirement Village's rest home on 8 October 2007.[5] He was initially admitted for respite care but became a permanent resident from 25 October 2007. The "Nursing Care Plan" completed soon after Mr A's admission showed that he was reasonably independent with his care and required minimal assistance from staff.

Dr P is a vocationally registered general practitioner who provides general practice services to residents at the Village.[6] Dr P first reviewed Mr A on 10 October. He noted Mr A's medical history:

> "NIDDM[7] (denies) 2001. Hearing aid. Peritonitis aged 17. TURP[8] — some cancerous cells prostate."

Metformin was recorded under medication. Dr P saw Mr A again on 17 October 2007, at which time Mr A queried why he was taking metformin. Dr P discontinued this and requested blood tests, including PSA, in three weeks' time.

Mr A's sons, Mr B and Mr C, advised HDC that at the time of Mr A's admission to the Village they informed staff that their father had previously had 3-monthly Lucrin injections for prostate cancer, and that following these injections he was inclined to be unsteady and more prone to falling. There is no record of this in the admission documentation. There is no reference in Mr A's previous medical records to Lucrin affecting his balance.

[4] Preliminary advice is used to inform the decision to investigate. Following the start of the investigation, independent expert nursing advice was not sought from RN Baker as she had previously worked for the owner of the Retirement Village, and this was identified as a potential conflict of interest. RN Rowe was then asked to provide the expert nursing advice for the investigation.

[5] Edmund Hillary Retirement Village opened in June 2007. It includes a care facility with a 92-room rest home (ground floor and second floor) and a 42-room hospital (first floor). It is owned and operated by Edmund Hillary Retirement Village Ltd, which is part of a larger company. References to the Village in this report include the owner of the Village.

[6] This is on a generic supplier's contract basis, with Dr P visiting the Village on a weekly basis for up to 5 hours and at other times when possible, usually an extra 2–3 times per week. There is an arrangement with an out of hours GP service, to provide services when Dr P is not available. Village residents are able to choose whether to use a contracted GP or another GP of their choice.

[7] Non-insulin-dependent diabetes mellitus.

[8] Transurethral resection of the prostate.

Medical notes, PSA monitoring and Lucrin
Mr B advised that he delivered his father's medical notes to the Village about a fortnight after his admission.

Soon after this, the notes were misfiled at Dr P's surgery, turning up again some time around 12 December 2007. Dr P stated that he had not seen Mr A's previous medical records before they were misfiled, although his entry on 17 October 2007 noted: "Review of notes — HbAC [glycosulated haemoglobin] never above low 7s". Dr P may have been referring to the Village's clinical records, but there is no evidence that these contain the information about HbAC. On 12 December 2007, Dr P noted that Mr A's current PSA was in the 5s, that he should have monthly PSA tests, and he should restart injections if the level rose above 10µg/L.

Mr A's PSA was next checked on 27 February 2008, when it was 9.8µg/L, and then on 20 August 2008, when it was 38.8µg/L. In his response to this investigation, Dr P initially advised that he had been monitoring Mr A's PSA, but subsequently acknowledged that there had been a failure to follow the recommended PSA testing, as documented by him on 12 December 2007. He explained that nursing staff at the Village usually place such instructions in a ward diary, but that he also failed to ensure this happened. Dr P accepts overall responsibility for this.

When Dr P was advised of Mr A's elevated PSA a few months later, he contacted Mr A's previous urology specialist. The specialist advised that Mr A should have a two-week course of cyproterone acetate (2x 50mg tablets twice daily) followed by a Lucrin injection. An enrolled nurse (EN) at the Village, Ms F, documented in the progress notes the following month that Mr B was notified of the change in medication. Mr A commenced the cyproterone acetate the next day, and had the Lucrin injection two weeks later. Dr P does not recall any discussion with family or Village staff at or prior to this time, about the effects Lucrin had previously had on Mr A's balance and falls risk.

The progress notes show no concerns or changes in Mr A's well-being following the Lucrin injection, until a reported fall later in the month.

Falls history
On admission to the Village, Mr A was noted to have good mobility with a walking stick, and a low risk of falling. Progress notes show that Mr A had two minor falls in April 2008. His family recall that he reported a further fall around May 2008, and that this resulted in a broken toilet. There is no record of this fall in the nursing notes, but the Village's maintenance records show that a broken toilet seat in Mr A's room was attended to on 7 May 2008. Mr A's care plan was updated at the end of May, when it was noted that he continued to use a walking stick, and his risk of falling was still low.

A few months later, Mr A fell in the dining room at the Village. He appeared uninjured and assured staff that he was fine. Five days later, Mr C noticed his father was limping, and Mr A admitted he had fallen in his room the previous day. Mr A again assured staff he was fine. Staff recorded both falls in the progress notes and completed "Incident Reports". Following the second of these falls, Mr A was

assessed by Clinical Manager Ms G as being at high risk of falling, and instructions were added to his care plan to address this.[9] It was noted that Mr A's room should be kept free of clutter, that he should be reminded to use his bell to call for assistance and to keep his walking stick at hand, and that all falls should be reported to a registered nurse and documented in the "Short Term Care Plan". Dr P checked Mr A three days later, noting some tenderness over the right hip but that he was walking.

Later that month, Mr A told care assistant Ms E that he had fallen in the toilet the previous night. Ms E recorded this in the progress notes, noting that she informed the senior care assistant on duty that night, but the senior care assistant does not recall this and there is no further reference to this fall.

Monday

Three days later, Mr A fell as he was getting up from his chair in the dining room after lunch. He assured staff he was not hurt, and was assisted to get up. Staff checked his blood pressure (130/90mm/Hg), pulse (101 beats per minute) and respirations (20–37 breaths per minute), and found no evidence of injury.[10] Mr A walked back to his room unaided.

EN Ms F completed an Incident Report, and noted in the progress notes that Mr A had fallen to his knees and knocked his arms, and that he should be observed for any bruising. EN Ms F informed Mr C of his father's fall. Mr C advised that following previous Lucrin injections, his father had been very sleepy, unsteady and prone to falls. EN Ms F noted this information on the Incident Report, in the progress notes, and on the Nursing Care Plan.

That evening, the senior care assistant noted that Mr A had complained of pain in his back, and at 6pm he was given Panadol.

The following day, Registered Nurse (RN) Ms G noted on the Incident Report that Mr A should be seen by a doctor "as soon as able to check out after fall". RN Ms G subsequently advised that her intention was that Mr A should be seen when Dr P was at the Village for his next scheduled visit, which would have been on Wednesday.

Tuesday

Fall and follow-up care

At 6am, care assistant Ms H found Mr A on the bathroom floor. She saw that Mr A had blood on his face. Ms H spoke with Mr A, asking him to stay where he was while she got a nurse. She went upstairs to the Village's hospital wing and sought

[9] Ms G is also a registered nurse.

[10] Normal measurements for the average healthy adult are: blood pressure 110–130/70–90 mm/Hg; pulse 60–80 beats per minute (bpm) at rest; respirations 12–18 breaths per minute (BPM); temperature 36.3–37.3°C.

the assistance of RN Mr I.[11] RN Mr I assessed Mr A while he was still on the bathroom floor, and applied pressure to control bleeding from his nose. RN Mr I and Ms H assisted Mr A to get up, and then helped him back to his bed. RN Mr I performed further checks, noting that Mr A was able to move all four extremities with no pain or difficulty, and that his pupils were constricted and reactive to light. He noted that Mr A's oxygen saturation level was 99% and his pulse was 102bpm. RN Mr I spoke to Mr A about going to hospital; both Ms H and RN Mr I recall that Mr A expressed a clear wish to be seen later by his GP rather than go to hospital. Ms H and RN Mr I completed their respective sections of an Incident Report, including a note from RN Mr I "[to] continue monitoring thru out the day". They updated EN Ms F, who was just coming on duty. RN Mr I subsequently stated that he had advised EN Ms F that Mr A should be seen by a GP "first thing in the morning". Before Ms H finished her shift at 7.15am, she checked on Mr A again and updated the progress notes, observing that bruises were starting to show.

At about 7.20am, EN Ms F phoned Mr C to inform him of his father's fall. She advised that they would request a visit from Dr P, and Mr C said he would come in to see his father. EN Ms F then went to see Mr A, did the medication round, and went back to Mr A. She suggested he should have a day in bed. Mr A said he did not need pain relief at that time.

At 8.30am, EN Ms F stopped RN Ms J as she was walking through the rest home and asked her to review Mr A. RN Ms J usually worked in the hospital wing but on this day she was participating in a file review and was not on clinical duties.[12] RN Ms J recorded Mr A's blood pressure (172/88mm/Hg), pulse (96bpm) and temperature (36.6°C) on the Incident Report and noted:

> "[Mr A] remains in bed, is tired but responsive, able to respond appropriately to questions, denies pain or nausea but does not wish breakfast. Reddened area above (L) eye with purple area from inner corner to mid eyelid 3½cm long. Area over (L) eye slightly raised [diagram included]. Also noted bruising to (R) elbow inner aspect — 4½cm x 1½cm and (R) knee 4cm x 2½cm [diagram included] is reddened. Both injuries to (R) side from yesterday's fall. See incident form 29/9/08. [Dr P] contacted to visit — pupils sluggish, no weakness noted."

RN Ms J also recalled Mr A saying that he did not want to go to hospital. She contacted the GP practice, thinking the call may have been early enough for Dr P to visit on his way in to his surgery as he sometimes did, and discussing this with the surgery practice nurse. RN Ms J understood that the practice nurse was going to phone back to confirm the time that Dr P would attend, and she informed EN Ms F accordingly. By that time RN Ms G had arrived. RN Ms J stated that she told RN Ms G that she had assessed Mr A and contacted the GP practice, and that the

[11] RNs from the hospital wing provided nursing input to the rest home when there was no RN/clinical manager on duty in the rest home. This was usually outside the hours of 8.30am–4.30pm, Monday–Friday.

[12] RN Ms J had been appointed Rest Home Manager but was not due to take up this position until 7 October 2008.

practice nurse should phone back to confirm the time of Dr P's visit. RN Ms G advised that although she was at work and that she did see Mr A, she was not "on the floor". RN Ms G recalled RN Ms J speaking to her about Mr A that morning, but also stated that RN Ms J was the registered nurse on duty that day. RN Ms G said she happened to go past Mr A's room later that day and spoke with him briefly. She said she was sorry to hear about his fall and noted that his eye was red. As this was informal contact in passing, she did not record it.

RN Ms J subsequently advised that both she and RN Ms G were participating in the file review, but she expected RN Ms G would have told EN Ms F whether she was going to be available or contactable that morning and, if not, who should be contacted if there were issues in the rest home.

A practice nurse at Dr P's surgery, recorded:

> "T/C from [Ms J]. Has had 2 more falls over past 18 hrs — bashing his head nastily. Pupils bit sluggish — answers appropriately. BP yesterday 130/90 but today after 2nd fall is 172/88. Would like him seen."

The Village advised in its response that it is generally accepted practice that GPs attend to residents during breaks in their surgery appointments, and that these are often between midday and 2pm or after 6pm. The request for Dr P was not conveyed as urgent, as Mr A's observations were stable, his responses were appropriate, he was mobilising, and he had initially declined pain relief.

There is no record of staff at Dr P's surgery phoning back to confirm the time of Dr P's visit. RN Ms J subsequently advised that had she been responsible for the rest home at this time she would have monitored Mr A closely, and that if she had heard nothing from the surgery within 20 minutes or so, she would have followed up to advise that a review was needed before lunchtime.

At 10am, EN Ms F again asked if Mr A needed pain relief, which he accepted. About an hour later, EN Ms F found Mr A in his bathroom, putting clothing into his laundry basket. She reminded him again to ring for staff assistance when needed.

Mr C arrived at about 11am, expecting that Dr P would see his father between midday and 1pm. Mr C later advised that he observed severe bruising and swelling to his father's left eye, and abrasions on his forehead. He recalls that his father had difficulty moving his head or body, and that he appeared to be in severe pain. He does not consider his father would have been capable of getting out of bed at this time.

Mr C left messages for Mr B, who had been out of the country but was due back that afternoon, and for Mr B's partner, Ms B. Mr C left before Dr P arrived.

Dr P's assessment

Dr P saw Mr A at about 1pm. He initially called in to Mr A's room on his way to the nurse's station. Dr P recalled that the main feature of note was the major bruising to the lateral (side) aspect of Mr A's left eye. Dr P noted that Mr A

commented on the fact that he, Dr P, was not due at the Village until the following day. Mr A initially denied any pain, and Dr P recalled that he showed no evidence of pain or distress. Dr P then went to the nurses' station and spoke with EN Ms F. EN Ms F advised Dr P that Mr A had been indicating pain in his upper back, and they returned together to Mr A's room. In his response to this investigation, Dr P stated that it had always been his intention to return to Mr A's room to complete his assessment, after he had been briefed by nursing staff. Dr P recorded in Mr A's progress notes:

> "Fall 1/7 ago, again this am. Apparently he does this when on Lucrin injections.
> OE [On examination] bruised swollen (L) eyelid. Vision✓
> PERLA [Pupils equal, react to light and accommodation]
> Knows is Tues. I am not due til Wed.
> Sore ribs (R) lower lat. [lateral] Clin nil # [Clinically nil fracture]
> Sore neck."

Dr P also recorded this visit in Mr A's electronic notes when he returned to his surgery. There are slight differences in the wording used and in this record Dr P also noted "NBI" [No bony injury].

Dr P subsequently described his assessment of Mr A:

> "At this first consultation he was able to move easily, and turned on the bed from a sitting position so I could examine around his chest. I examined his chest because the nurse informed me that he had possibly injured that in one of his falls. There was some tenderness about the right side of his chest (it took a little time to determine which side, as he kept denying pain), but this was localised, with no tenderness or discomfort when the ribs were palpated away from the immediate area of tenderness.[13] It seemed perfectly reasonable to observe him, and Panadol seemed to be the only pain relief that might be needed."

He stated further:

> "I checked the eye with a torch for visual inspection, and papillary reaction, and palpated the bony structures about the eye. There was some tenderness, but no more than I considered consistent with the bruising that was apparent. There was no bony ridging, or anything that I considered indicated the likelihood of a significant fracture. Once I had found the nurse involved with his care, and been told that he had apparently also hit his chest, I palpated about the chest, and auscultated for air entry.[14] There was minimal tenderness about the right chest wall that [Mr A] denied as being a problem or significant. I palpated his abdomen while he was sitting, and this was soft, with no tenderness."

[13] Palpation is part of a physical examination in which the health care practitioner feels the part of the body to determine its size, shape, firmness or location.

[14] Auscultation is listening to the sounds made by internal organs, usually with a stethoscope.

EN Ms F also recalled that when she and Dr P returned to Mr A's room, Mr A indicated that he had pain in his upper back and neck, but also continued to say that he was all right. She stated:

> "[Dr P] asked [Mr A] to stand up, he checked his ribs and moved [his] head left and right. [Dr P] particularly noted this area. He also checked [Mr A's] face closely and felt around his nose, as he gently moved [his] nose [Mr A] did not make any comments about pain."

EN Ms F recalled that she asked Dr P about stronger pain relief for Mr A. Dr P advised that four-hourly Panadol as required should be adequate, and that he would review Mr A the following day. Dr P stated that he advised staff to monitor Mr A's condition but gave no specific monitoring instructions, as his injuries seemed superficial and were not troubling him. Mr A had Panadol at 2pm.

Further care
EN Ms F updated the progress notes before the end of her shift at 4pm, noting Dr P's plan to review Mr A the following day and that Mr B intended to be present for that visit. She also initiated a "Pain Assessment Evaluation Form", recording Mr A's assessment of his pain as six out of ten, and her assessment of his pain as four out of five. The time of this assessment is not given.

EN Ms K was on duty from 3 to 11pm. She noted that Mr A had declined to eat, and that he had his usual medication and Panadol with good effect. It was later noted that EN Ms K had omitted to sign the drug administration record to show Panadol had been given.

Mr B and Ms B were with Mr A from about 3.30pm until 7pm. They recalled that Mr A was drowsy and in pain, and that his breathing was shallow and laboured. Ms B stated that Mr A indicated to her that he thought he was dying. She noted this in the context of his history of denying pain. Mr B stated that soon after they arrived, he spoke to nursing staff about the need for his father to go to hospital, and that he was advised that his father had been seen by Dr P and was ok. They were reassured by staff that Mr A would be monitored through the night. Their previous experience of care at the Village had been good, and they trusted the staff.

Care assistant Ms L was on duty overnight. She recorded that Mr A slept all night and that there were no concerns.

Wednesday

Ms L recalled that when she checked on residents at around 6am, Mr A was sitting on the side of his bed, shaving. Mr A said he was all right and that he did not want any pain relief.

Later that morning, care assistant Ms M noted that Mr A had eaten breakfast but that he still seemed "dazed" and was complaining of a sore right shoulder. She thought his eye looked sore, but Mr A said it was fine. Ms M assisted Mr A to wash and dress. EN Ms F gave Mr A his morning medication at about 9am, including

Panadol. Ms M checked on Mr A again at about 10.30am and noted that he was in his chair, having morning tea.

Later that morning, EN Ms F noted on the Pain Assessment Evaluation Form that Mr A had complained of more pain in the ribcage area, and that Panadol was not helping.

Mr C and Mr B arrived at the Village just before midday, expecting that Dr P would be seeing their father between midday and 1pm. They recalled that Mr A was sitting in his chair beside the window, but leaning towards the right and breathing quite loudly. They thought that he again appeared to be in a lot of pain, and Mr B went to the nurses' station for assistance. EN Ms F said she would get some Panadol, but when Mr B suggested his father would not be able to swallow this, she said she would get Pamol elixir (liquid paracetamol) from the hospital wing. In the meantime, Ms M, and Mr C and Mr B moved Mr A from the chair back to his bed. Mr C noticed that there was vitamin powder in his father's glass, indicating he had not had his vitamin drink before breakfast, as was his routine. EN Ms F returned with the Pamol elixir, which she gave to Ms M to administer. Ms M did not recall Mr A having any particular difficulty swallowing this. Mr B observed that his father was having a lot of trouble swallowing and that Ms M tried three times to administer the Pamol. Mr C also recalled that his father was not able to swallow easily, and that Ms M commented on this to EN Ms F.

Dr P's visit

Dr P had arrived at the Village at about 10am for his scheduled round and, as is usual, began by seeing patients in the hospital wing. He went down to the rest home on the ground floor at about 2pm and was asked to see Mr A first. Until then, Dr P was unaware that there had been any deterioration in Mr A's condition. Mr B and EN Ms F were present.

Dr P advised that he saw immediately that Mr A's condition had deteriorated. He was more drowsy, in obvious pain and distress, slightly short of breath, and had difficulty moving. There was tenderness about the right chest wall, and Dr P considered that there were clinical indications of a rib fracture.

Dr P wrote in Mr A's clinical records:

> "C/o [Complains of] pain about chest. Is more sleepy and sluggish. O/E [On examination] Slight dyspnoea [difficulty breathing]. Is tender about (R) lower lateral chest, possible rib #. Chest slight creps (R) lower base.
>
> → [Public Hospital]."

Arrangements for hospital admission

Mr B stated that he suggested his father needed to go to hospital and Dr P agreed. Dr P advised that he had no doubt that hospital admission was needed. EN Ms F also recalls that this was Dr P's suggestion.

According to Mr B, Dr P then asked if he would take his father in his car, to which he replied, "You must be joking, he needs an ambulance." EN Ms F's understanding is also that Dr P suggested Mr B could take his father to hospital, although she does not recall Mr B's response. Dr P said that his question was not about transportation, but to ascertain Mr B's view on hospital admission itself. Dr P said that although there was no doubt in his mind that hospitalisation was necessary, he was aware that some families prefer treatment options that avoid the need for moving about, and he needed to establish whether that was Mr B's view.

Dr P and EN Ms F then returned to the nursing station to make the necessary arrangements for Mr A's admission to the public hospital. Dr P wrote a referral for admission, noting "?pneumonia, ?rib #, ?needs skull CT". Dr P spoke with a registrar at the public hospital, and then handed the phone to EN Ms F to arrange the ambulance. The St John Ambulance transcript confirms that this call was made at 2.26pm, and that when EN Ms F was asked what priority the ambulance request should be, the person she checked with replied "no" or "low" priority. The ambulance dispatcher then said that an ambulance should be there within the hour. The Village noted in its response that EN Ms F recalled that Dr P was sitting beside her writing the referral note while she was speaking with the ambulance dispatcher, and that she checked with Dr P when asked about the priority of the ambulance.

Dr P stated in his response that there was miscommunication between himself and Village staff regarding priority of ambulance transport needed. He said:

> "[I]t did not need to be immediate (flashing lights and siren), but that this was communicated to St Johns by nursing staff in a way that became routine transport, and took several hours. It was my intention that it should have been Priority 2 — within 30 minutes."

He said that he did not intend for a non-urgent ambulance, but his "intentions were not expressed and/or heard adequately for them to be carried out as [he had] wished".

The ambulance arrived at the Village at 3.50pm. The ambulance officer noted that Mr A had fallen the previous day and the day before that, and that one fall had left him with "a very bruised L) eye and a strong headache esp [especially] in the frontal area" and the other had left him with "rib pain esp across the back". It was noted that Mr A was alert and that he complained of pain as above but denied "chest pain aside from rear ribs area". It was noted that he had been given paracetamol within the previous four hours, and that he was able to mobilise with much assistance and some pain. Observations at 4.04pm showed that Mr A's respiratory rate was 20BPM, pulse 92bpm, oxygen saturation 97%, a Glasgow Coma Scale of 15 (indicating the patient is fully conscious and aware), temperature 37.1°C, and blood pressure 170/105mmHg. At 4.17pm his blood pressure was 137/93mmHg and his pulse was 96bpm. Mr A arrived at the public hospital at 4.20pm.

When RN Ms G was advised of Mr A's admission to the public hospital she reviewed his file and completed a "Recent Falls Analysis" form, summarising Mr A's falls since April 2008.

Subsequent events

The Public Hospital

Mr A was triaged in the Emergency Department (ED) as category 3.[15] The findings of the ED Registrar included: "[l]ooks unwell", "dehydrated", "warm" and "well perfused".[16] The head and neck examination confirmed extensive bruising around the eye but no specific bony tenderness, and no neck pain but extremely limited range of movement. It was noted that Mr A was able to look left and right, but not up and down. The chest examination showed:

> "Very tender (R) lat + (R) post ribs
> No bruising visible
> Not dull. Normal resonance
> Nil Crackles"

Mr A was given morphine and intravenous fluids.

The confirmed X-ray and scan reports showed that Mr A had a comminuted left superior orbital fracture.[17] He also had an odontoid peg fracture (cervical spine at C2). There was also a possible fracture of the fusion between the 2nd and 3rd vertebrae, but it was noted that this may have been old and it was not reported in the subsequent orthopaedic summary. X-Ray reports also showed that Mr A had severe ankylosis and osteophytes of the cervical spine.[18]

Mr A's care was transferred to the Orthopaedic Service. The treatment plan was to use a collar to immobilise Mr A's neck, bed rest, pain relief and chest physiotherapy. Mr A was moved to Ward 77 at 12.45am the next day. Later that morning he was seen by a physiotherapist for respiratory issues, and by a speech language therapist because of his swallowing difficulties.[19] However, Mr A's respiratory function continued to deteriorate and, in the early evening, family were advised that his prognosis was poor. Mr A died at 8.45pm.

The cause of death was recorded as upper airway obstruction with a background of aspiration pneumonia, rib fractures and a C2 fracture, although there was no evidence from the radiological reports provided to HDC that Mr A had sustained a

[15] Triage 3 categorisation means the patient should be seen by a doctor within 30 minutes of presentation.

[16] The time of the Registrar's assessment was noted as 6.30pm but it would appear that assessment had begun some time earlier as notes include the findings of initial X-Rays and scans.

[17] The bone around Mr A's left eye socket was broken, splintered or crushed into a number of pieces.

[18] Fusion of the neck bones as a result of longstanding osteoarthritis.

[19] In March 2008, Mr A had been seen by a speech language therapist, who identified poor swallowing ability and increased risk of aspiration due to suspected pooling of fluids.

new rib fracture. "Senility, Dementia of Alzheimer's type" was also noted on Mr A's death certificate as a significant condition contributing to his death but not related to the disease or condition causing it. There were references in Mr A's public hospital clinical notes to mild memory loss and MMSE results of 27/30 and 23/30.[20] Dr P was not aware of any diagnosis of dementia from Mr A's medical records, and Mr B and Mr C similarly report no knowledge of this.

Follow-up with the Village and Dr P

Mr B had met with Ms G and Facility Manager Mr N shortly before Mr A died, to discuss what had happened and the family's concerns about the care Mr A had received at the Village.

A few days later, Mr C and Mr B, and their sister, Ms D, met with Mr N and the Regional Manager, Ms O. Mr A's family were not satisfied with the response they received at this meeting.

Later that day, Mr B and Ms D met with Dr P. Mr B recalled that at this meeting Dr P expressed concerns about the level of communication between nursing staff and himself, and that he classified the home as a "C+" for nursing care. Dr P advised HDC that the staff he had met at the Village were almost universally of a good to high standard, but that the facility has been affected by two problems. The first was in opening progressively while building and development was continuing, which led to multiple difficulties. This included not having enough staff when a new floor opened, although Dr P did not consider this was a problem at the time of Mr A's falls. The second is in relation to the nationwide problem of finding sufficient nursing staff. Dr P stated:

> "While [the Village] does struggle to maintain adequate nursing staff levels, and therefore I do not put them in a higher rating, I believe that Mr A was cared for by some of the most competent staff in [the Village], with whom I have no issues. I do not consider that staffing levels played any significant part in what happened to him."

When the Village was advised that Mr A was dehydrated on admission to the public hospital, staff who had been providing care to Mr A on Tuesday and Wednesday were asked to note down any additional recollections they had in relation to what Mr A had had to eat and drink during this time. These statements were made a few days after Mr A's death.

Later that month, Mr B submitted a written complaint to the Village (and to HDC, the District Health Board, and the Ministry of Health) on behalf of Mr A's family. On receipt of this, the Village requested a review of the care provided to Mr A by geriatrician Professor Tim Wilkinson. Professor Wilkinson highlighted the difficulty in preventing falls in residential care. He noted that following Mr A's fall

[20] The Mini Mental Status Examination (MMSE) is a 30-point questionnaire commonly used to screen for dementia. A score above 27 indicates no impairment, while 20–26 indicates some cognitive impairment.

on the Tuesday prior to his death, he was attended to promptly by a nurse and then twice by his GP. In his view, the actions taken were appropriate and timely. He noted that any more urgent attention would have required calling an ambulance and direct admission to hospital. In his view, even if this had occurred, the same diagnoses would have been reached, the same care would have been provided, and therefore the same outcomes would have been likely to occur. Professor Wilkinson noted the difficulty in determining whether more attention could have been given to ensuring Mr A's comfort, given the conflicting views on the level of pain he experienced and the levels of pain relief offered.

A few weeks later, the Chief Executive Officer Mr Q, and the Operations Manager met with Mr B to discuss the complaint. Mr Q wrote to Mr A the following week, summarising actions that had been taken in response to the complaint. Mr Q acknowledged the family's concern and distress, and extended an apology.

Mr Q subsequently advised HDC that he considered they had been able to address the issues in the complaint with the exception of a request from the family for financial compensation. This was requested to cover costs incurred, compensation for the emotional and physical trauma suffered by Mr A, and compensation for the emotional trauma suffered by his family.

In March 2009, the Village made an offer of compensation to Mr A's family, based on a refund of deluxe room charges and a contribution to the cost of airfares.[21] Mr Q noted that the "investigations etc" were taking a considerable toll on Village staff, and the actions that had already been taken to address the concerns raised by the complaint. The offer was made on the condition that Mr A advise HDC that the outstanding concerns had been addressed to his satisfaction. The offer was declined by Mr A's family.

Falls policy and training

A copy of the Falls Management policy effective at the time of these events is attached as **Appendix C**. The policy outlines the various actions to be taken in the event of a resident falling, and states that if there is a registered nurse on duty, she should be called before the resident is moved. The policy states that if the resident is knocked out briefly or has hit his or her head, the resident's GP or an after-hours doctor should be notified. Observations should be taken, including blood pressure and pulse, pupil reactivity, level of consciousness and orientation. Observations should continue at 30-minute intervals until the resident has been seen by a medical officer for further instruction.

The owner subsequently advised that nursing staff are made aware of the Village's Falls Management policy during their orientation and induction programmes, and during ongoing routine in-service education. It confirmed that all of the staff involved in Mr A's care had completed the relevant induction sessions, and an in-service training session on falls in April 2008. RN Mr I had attended a training

[21] Ms D was overseas at the time of her father's death.

session relating to incidents/accidents (including falls), documentation and reporting system in August 2008. RN Ms J had attended a seminar on clinical risk (including falls) in August 2008.

Ministry of Health and the District Health Board

A routine audit at the Village had been carried out at the direction of the District Health Board a short time prior to these events. This identified partially attained criteria in relation to medication management, recording of general practitioner information, medication reviews, pain management, recording of falls risk assessments, residents' privacy, and Māori health.

After Mr B's complaint to HDC was submitted to the Ministry of Health and the DHB, an unannounced issues-based audit was undertaken by HealthCERT on 21–22 October 2008.[22] This identified significant issues relating to pain management, falls, medications, staffing, resident weight loss, and admissions to the Village. It was noted in the audit report that the Village had developed a Quality Improvement Plan (QIP) to address the increased incidence of falls. This plan recommended continuous review of high risk residents' care plans, and more prompt intervention in seeking input from a GP. HealthCERT also noted limited use of falls prevention equipment such as sensor mats, hip protectors and lifting belts, and limited use of neurological observations after resident falls that result in head injuries.

The report outlined a number of corrective actions to address the concerns identified, to be implemented with clinical oversight from the DHB. These included requirements for the Village to:

- confirm the implementation of actions outlined in its QIP to address the increased incidence of falls;
- develop "Falls Risk Management Plans" for individual residents, to be used in conjunction with consistent incident reporting, use of neurological observations for head injuries, and repeat falls analysis to support staff in caring for residents with high falls risks;
- confirm that appropriate falls prevention equipment is available to residents assessed as having a high falls risk, and the provision of appropriate staff training in the use of this.

Progress reports in relation to compliance with certification conditions were provided by the Village on 15 December 2008, 19 January 2009 and 5 February 2009. These indicated that the corrective actions were being taken.

HealthCERT staff revisited the Village on 25 February 2009, the owner undertook an internal audit at the Village on 25–26 March 2009, and the Village's designated auditing agency carried out a surveillance audit on 7 May 2009.

[22] HealthCERT is the Ministry of Health's agency responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers.

In addition, arrangements were made in December 2008 for a DHB Nurse Advisor to provide clinical oversight to the Village, and for multi-disciplinary meetings to be held with the DHB's Clinical Director of Gerontology every six weeks over the coming year.

The DHB and HealthCERT subsequently advised that they are satisfied with the changes and the outcomes of their respective enquiries, and closed their reviews of the Village's service on 11 August 2009.

Changes at Edmund Hillary Retirement Village

The Village has made a number of changes as a result of this complaint and what happened with Mr A. These are:

Falls

- A Falls Assessment and Intervention flowchart was developed shortly after this incident. This was implemented at the Village on 8 October 2008, through a compulsory in-service training session. The purpose was to ensure all registered staff respond to a fall event in the same manner.
- The Operations Team undertook a full review of the generic "Falls Management Policy". A new policy and documentation (a "Falls Management Plan") was implemented across all facilities on 31 October 2008. This requires staff to:
  - Complete a "Falls Management Plan" in the event a resident falls with injury or sustains a head injury.
  - Call an ambulance if the GP/after-hours service is unable to attend the resident within a two-hour period, if the registered nurse/senior is at all concerned for the resident's condition.
  - Undertake ongoing observation and a full assessment 24 hours post-injury.
- The "Falls Management Plan" was reviewed and modified in December 2008. It was extended to include a more user-friendly "Falls Response Protocol", and this was implemented across all facilities on 10 December 2008. This includes a specific protocol for monitoring, and a food and fluid intake record is included in the checklist of potential implementation interventions. The "Falls Management Policy" was updated accordingly.
- A monthly "Falls Collation Register" has been developed. This is not particular to a resident but records all falls within each wing of the facility. It is additional to the "Incident Form" and "Falls Management Plan".

Nutrition and hydration

- Nutrition and Dehydration policies were reviewed and sent out to all its facilities on 31 October 2008.
- A mini weight audit commenced across all facilities on 26 November 2008.
- A new "Nutritional Assessment" tool was issued on 10 December 2008, and the Nutrition policy was updated accordingly.

Other changes

- Spot audits of all facilities (using a key risk audit tool) were completed by 24 November 2008.

- A review of the policy for GP reviews and medication reviews was completed by 26 November 2008.
- The "Pain Assessment" tool was reviewed, and re-issued on 10 December 2008.
- The electronic Village Care Plan programme was reconfigured to ensure a resident's falls risk is specifically monitored within this programme. It is not possible to exit from this document without identifying the falls risk level and initiating the specific interventions appropriate to the level of risk identified.
- Review of Clinical Governance:
  - A Senior Clinical Manager was seconded to the Village in September 2008.
  - A Residential Care Manager position was created at the Village, and clinical roles in the rest home and hospital were restructured in October 2008.
  - A Clinical Services Manager was appointed in February 2009.
- The results of a residents' relatives' satisfaction survey were reviewed.
- EN Ms K was disciplined for failing to complete the medication administration record. She has undertaken further training to ensure compliance with medication protocols.

Changes made by Dr P

Dr P has outlined several changes made prior to, at the time of, or since, the events outlined in this complaint.

- Early in 2008 Dr P and the Village formalised an arrangement for the medical records of Village residents to be held at the Village.
- Dr P has changed the filing system at his surgery, with records now being stored in a larger room on shelves specifically installed for proper filing and retrieval, to avoid records being "lost" again.
- Dr P now has a laptop computer for use away from his surgery. Notes from consultations are printed out for Village staff to attach to residents' files, while Dr P retains the information on his practice system so that he is able to answer questions that arise when he is back at his surgery. This system also allows for recalls to be entered by staff at his surgery.
- Dr P does not accept that there was a clinical failure in his assessment of Mr A but advises that he is now more proactive in seeking a fuller assessment of elderly patients after falls or injury.

When my provisional findings were sent to Dr P, I recommended that he perform an audit of his rest home notes and consider what improvements could be made in his clinical documentation. Dr P completed an audit in October/November 2009. This identified a need for fuller recording of medical examinations, especially when residents are admitted.

Response to provisional opinion

Most matters raised by the Village in response to my provisional findings have been incorporated into the previous section. I note also the following:

The Village considers the response from staff to Mr A's fall on the Tuesday before his death was reasonable. It advised that neither RN Mr I nor RN Ms J, the registered nurses who assessed Mr A that morning, were on duty in the rest home that day, and their advice was sought for assessment purposes only. Mr A did not want to go to hospital, and he was mobilising, lucid, and not expressing significant pain. The Village advised that on this basis, staff had no reason to seek urgent GP assistance, to send Mr A to hospital, or to undertake detailed monitoring. Staff were not required to follow steps 2 to 4 of the Falls Policy, because Mr A was able to mobilise immediately afterwards and go about his normal routine. They pointed out that the judgement of the registered nurses and rest home staff is supported by Dr P's assessment later that day.

The rest home was being managed by EN Ms F. In the Village's view, communication between RN Ms G and RN Ms J was not relevant to the delivery of Mr A's care in the rest home, as neither was in charge of the rest home that day.

The Village noted the efforts it makes to discharge its obligations as a provider, in relation to staff compliance with policies. In addition to orientation and education programmes, it undertakes extensive internal auditing at all its facilities.

Expert nursing advice
The Village also provided its own expert nursing advice from registered nurse Beverley Rayna.

Ms Rayna noted the difficulties rest home staff can encounter when they send residents to hospital. She stated that emergency department staff are very resistant to referrals from rest homes, and ambulance staff will sometimes decline to transfer patients.

Ms Rayna considers RN Mr I's assessment, first aid and documentation could have been fuller, but that overall his care was reasonable in the circumstances. She considers it was quite in order for him to hand over to the morning staff and rely on them to monitor Mr A appropriately and arrange medical review. It is likely that an after-hours doctor would have advised requesting a review from Mr A's own doctor. Ms Rayna considers that taking into account the time of day, Mr A's recordings and wishes, and the wider context in relation to rest home referral to hospitals, RN Mr I's decision not to arrange transfer to hospital was reasonable.

Ms Rayna does not consider it was RN Mr I's responsibility to direct the EN on duty that morning in relation to ongoing monitoring. While ENs practise under the direction and delegation of a registered nurse, they must also abide by the facility's policies and practice. EN Ms F should have been as conversant with the falls prevention and management policies as RN Mr I.

Ms Rayna considers that the standard of documentation could be improved, noting that Mr A's care plan was only marginally adequate. She suggests that the wording of the Village's Falls Management policy is too vague and unreaslistic. She states that "a balance between the safety of the resident and the protection of the reputation of the rest home has to be achieved and policies should not be so risk averse as to be impossible to implement".

Ms Rayna discusses the issue of monitoring, noting that a resident is being monitored if staff are interacting with the resident, by offering food or fluid, conversing, checking for pain and reporting to the RN as required.

Ms Rayna concludes that while some aspects of Mr A's care could have been improved, in the circumstances the standard of care provided was satisfactory.

In light of concerns raised by the Village, expert advisor registered nurse Margaret Adams was asked to review my provisional findings and RN Rayna's advice. The Village was then given the opportunity to respond to RN Adams' comments.

Opinion

Introduction

Falls among older people are common, and the consequences can be devastating. Approximately one-third of people aged 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.[23] In New Zealand, falls accounted for 76.6% of all hospital admissions for unintentional injuries among those aged 75 to 84 years between 2000 and 2004.[24]

While not all falls result in injury, about 20% require medical attention. Of falls that do result in injury, one of the most severe conditions is a fall-induced cord injury or fracture to the cervical spine, alone or in combination. At a population level these injuries are relatively rare.[25]

It is unrealistic to expect that residential care can totally prevent falls. Nonetheless, careful management should reduce the incidence of falls amongst residents with health conditions that put them at greater risk of falling, and it should increase the likelihood that a person will receive prompt medical attention if he or she does fall. Unfortunately, as GP expert Dr Kerse notes, there is "… a large capacity in primary

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

[24] http://www.otago.ac.nz/IPRU/FactSheets/FactSheet39.pdf

[25] Kannus et al, see footnote 24.

nursing and medical residential aged care for increased knowledge and practice related to management of falls".

From all accounts, Mr A maintained a good quality of life until the week before he died. He enjoyed regular contact with his family and other residents at the Village, and he endeavoured to maintain his independence as much as possible. Indeed, he was described as "fiercely independent" and "stoical". He was determined that he should not be any trouble. It is accepted that this may have made it more difficult for Dr P and Village staff to identify the degree of Mr A's pain and discomfort. It also appears that the deterioration in Mr A's condition occurred quite rapidly on the Wednesday morning. For Mr A, the risk of serious injury from a fall was increased by the fact that he had severe ankylosis of the spine, a fact not known until the day before his death.

Good aged residential care is dependent on services being provided with reasonable care and skill. It requires the co-operation of everyone involved, and effective communication — between health professionals and with residents and families. While aspects of the care and treatment provided to Mr A were satisfactory, I consider that there were shortcomings, and that Mr A's rights under the Code of Health and Disability Services Consumers' Rights were breached.

Breach — Edmund Hillary Retirement Village

Mr A had the right to expect that if the need arose, Village staff would provide, and arrange access to, appropriate care in a timely manner. I do not consider that the Village met its responsibilities in this regard. While I have some concerns about the judgement and actions of individual nursing staff following Mr A's fall two days prior to his death (discussed later), the Village had responsibility for ensuring staff provided services to Mr A with reasonable care and skill, and that Mr A received good quality care.[26] In my view, staff did not work together and communicate effectively with one another, and with Dr P, to ensure Mr A was provided with quality and continuity of services, at a time when he needed it most.[27]

Nursing care following fall on Monday
When Mr A fell in the dining room on Monday, he got up with assistance and assured staff he was all right. He was checked by nursing staff and walked back to his room unaided. EN Ms F asked that staff coming on duty later that day check for bruising. She advised Mr A's family, and recorded the information about increased unsteadiness following Lucrin injections.[28] I agree with my nursing expert that this

[26] Right 4(1) — Every consumer has the right to have services provided with reasonable care and skill.

[27] Right 4(5) — Every consumer has the right to co-operation among providers to ensure quality and continuity of service.

[28] Mr B is certain that Village staff were informed of Mr A's increased falls risk following Lucrin injections when he was admitted to the Village. There is no evidence of this in Mr A's records.

was an acceptable level of care, but that it would have been appropriate to monitor Mr A's vital signs over the following 24 hours.

It is unclear from RN Ms G's note on the Incident Report for this fall that her intention was that Mr A should be seen by Dr P on his next scheduled visit, which in this case was two days later, and that "as soon as able" did not necessarily mean that day. In my view, this was not sufficiently clear communication.

Nursing care provided following fall on Tuesday
The nursing care provided to Mr A following his fall the next morning, and the communication between staff at this time, is of greater concern.

The Village's policy for managing falls at this time was that if a resident falls, baseline observations should be taken. In addition, if a resident has been knocked out briefly or has hit his or her head, the resident's GP or an after-hours doctor should be notified. Observations should continue at 30-minute intervals until the resident has been seen by a medical officer.

RN Mr I assessed Mr A just after 6am. He checked and recorded Mr A's pulse and oxygen saturation level.[29] There is no evidence that blood pressure or blood sugar levels were checked. RN Mr I spoke with Mr A about going to hospital, and stated that he thought this was advisable. However, Mr A expressed his preference to see a doctor rather than go to hospital, and RN Mr I accepted this. RN Mr I said he told the morning staff that Mr A needed to be seen by a GP "first thing in the morning" (meaning that same morning) and "asap". In fact, it was more than two hours later that the request was made for a GP visit, and more than four hours after that that Dr P arrived. RN Mr I's intentions were either not communicated clearly or not followed through on. RN Mr I noted on the Incident Report that staff should continue to monitor Mr A throughout the day, but he did not specify the level of monitoring required or put this instruction in the progress notes.

Ms Rowe advises that it is the responsibility of the registered nurse to make decisions about a client's level of need and when to insist on further assessment. In response, the Village noted that Mr A did not lack competency in his decision-making, and staff respected his wishes. It expressed concern at the suggestion that staff should have overridden Mr A's clearly and consistently articulated wishes. I sought further comment from my expert in relation to this. Ms Rowe states that while Mr A clearly articulated his wish not to go to hospital, RN Mr I should still have sought an assessment. A phone call to the GP or on-call doctor may have indicated to the registered nurse exactly what monitoring was required until such time as Mr A was medically assessed. Ms Rowe notes that assessment is not the same as transfer to hospital. She remains of the view that Mr A had had an unwitnessed fall and that RN Mr I should have sought further advice. I agree. I am not suggesting that Mr A did not have the right to be involved in his own care. However, he also had the right to a proper assessment of his injuries, and an

[29] It is noted that equipment to measure oxygen saturation levels would not normally be available in a rest home.

explanation of the treatment he required on the basis of this assessment. If he still did not want to go to hospital, he needed to be informed of the risks and potential consequences so that he could make an informed decision.

I accept that balancing the duty of care and patient autonomy can be difficult, but ultimately it is the staff's responsibility to ensure that rest home residents receive prompt medical attention when necessary. RN Mr I considered that Mr A should go to hospital for assessment of his injuries. If Mr A was adamant about not going to hospital, RN Mr I should at least have contacted the after-hours GP service promptly for a more immediate medical response.

The Village's nursing expert, Ms Rayna, has advised that rest home staff need to consider the day-to-day realities of accessing GP, ambulance and emergency department services. I accept that. However, it is not for staff to second guess how those services might respond, and to not refer on that basis (and I do not consider that they did so in this case).

At 8.40am, RN Ms J reviewed Mr A. She checked Mr A's vital signs, including his blood pressure and temperature, and recorded her findings. She also noted Mr A's wish not to go to hospital, and appropriately contacted Dr P's practice. She subsequently advised that she thought the call might have been early enough for Dr P to have come on his way to his surgery, although the Village maintains staff knew that it was usual practice for GPs to visit between midday and 2pm or after 6pm. RN Ms J considered Mr A needed to be seen by a doctor that morning.

When RN Ms J left the rest home after reviewing Mr A, she understood that the practice nurse was going to phone back to confirm the time of Dr P's visit, and she discussed this with EN Ms F and RN Ms G. However, there was no follow-up with the practice nurse, and Mr A's vital signs were not checked again until Dr P arrived.

RN Ms J and RN Ms G were both involved in a file review off the floor. Nonetheless, RN Ms G thought RN Ms J was the registered nurse covering the rest home that day, while RN Ms J thought RN Ms G was responsible or that she had confirmed alternative cover arrangements with EN Ms F. It was not clearly understood that there was no RN on duty in the rest home that morning. Had that been known, instructions to the ENs and caregivers looking after Mr A that day may have been more specific and more clearly documented. Again, there was a failure in communication between staff.

Ms Rowe notes that a review by a registered nurse would have been appropriate. As it was, Mr A was not assessed again by a registered nurse before his admission to the public hospital the following afternoon.

Head injury and falls management

In its initial response, the Village stated that there was no evidence that Mr A had a head injury. Mr A had had an unwitnessed fall, resulting in a bleeding nose. Less than two hours later, bruising around his left eye was becoming evident, and his pupils were sluggish. When RN Ms J contacted the GP surgery, the practice nurse recorded "nasty bash to head". At this stage, consideration should still have been

given to the possibility of a head injury; I do not accept the Village's position that staff had sufficient information to assume that Mr A had a facial injury only.

I accept that in the absence of any instruction in relation to head injury monitoring from Dr P *after* his assessment of Mr A, it was then reasonable for Village staff to proceed on the basis that this was not necessary. However, until that time, closer monitoring was required. Dr P's assessment cannot be used to justify the earlier actions of the nursing staff.

The Village's Falls Management policy at this time met the requirements of the DHB's auditing agency. I note that the issues that were flagged following the audit carried out shortly before Mr A's death were about the need to record an assessed level of risk, to include a detailed risk management plan in residents' care plans, and to incorporate the tools used in the falls risk assessment process into the policy. However, the fact that the policy was signed off by the auditing agency does not demonstrate that the Village fulfilled its duty of care. My concern is the way in which staff implemented — or failed to implement — the policy. In particular:

- RN Mr I's initial assessment of Mr A's condition was incomplete;
- it was more than two hours after Mr A was found, before a medical review was requested;
- Mr A's vital signs were not monitored every 30 minutes between his being found on the floor and being seen by Dr P.

I accept that monitoring Mr A's vital signs during this time, and an earlier medical review, may not have changed what occurred subsequently, but it may have led to earlier recognition of his deterioration and an earlier response. It may also have provided Dr P with more information when he assessed Mr A.

Staff looking after Mr A following his fall on Tuesday did not comply with the Village's own policy. While I accept that steps had been taken to make staff aware of the policy, the Village has a responsibility to ensure compliance. It is not enough to have policies and procedures and to cover these off through orientation and education programmes if staff still do not follow them. The risks of non-compliance with policies have been highlighted in investigations involving care at other rest homes.[30]

Ms Rayna suggests that the policy was too vague and unrealistic. Nevertheless, it was the policy in place at the time. Policies can and do include provision for staff to use their discretion and make decisions based on clinical judgement. The Village has submitted that this is what staff did here. However, the falls policy contained no such provision and, in the absence of this, the expectation should be that staff will follow a policy as it is set down. If there are particular circumstances requiring staff to act contrary to a policy, the reason for doing so should be explained and documented.

[30] 08HDC17105 and 07HDC16959.

It appears that a number of staff failed to adhere to the relevant policy. RN Mr I's note in the Incident Report did not specify the type or frequency of monitoring required, and he did not record this in the progress notes. It could be argued that he did not need to specify this as it was set out in the policy and he could expect his colleagues to follow this. However, I consider RN Mr I should have been more explicit about the monitoring required. It is difficult to conclude that RN Mr I intended his colleagues to follow the monitoring requirements of the policy when his own baseline assessment had been incomplete. RN Ms J did not document the need for continued observations because she had handed over to another registered nurse, and she said she expected her colleagues to follow the policy. RN Ms G did not record any monitoring instructions because she was not on clinical duties and thought RN Ms J was on duty in the rest home. While I accept Ms Rowe's advice that enrolled nurses work under the guidance of registered nurses, as Ms Rayna notes, they should also have been aware of the policy. It is not clear why EN Ms F did not seek clarification from a registered nurse about the need for continued observations.

I also note that although the policy passed audit standards, the Quality Improvement Programme in relation to falls that was developed by the Village following these events recommended more prompt attention in seeking input from a GP. The revised policy provides greater clarity in relation to the responsibilities of staff in the event that the GP or after-hours doctor is not able to attend within two hours of a fall. The Village is to be commended for the action it took when the high incidence of falls that month became apparent.

Pain relief

It is accepted that Village staff provided pain relief in accordance with Dr P's instructions. EN Ms F asked explicitly about the need for stronger pain relief, and Dr P advised that Panadol should be adequate. This was prescribed "as required". There is evidence from the notes that staff asked Mr A about pain regularly, and there were occasions when he was offered pain relief but declined it. I accept that Mr A's stoicism and reluctance to be any trouble affected the extent to which he articulated his pain and discomfort. It appears that this varied throughout the three days. His responses may also have depended on who he was speaking with.

Documentation

The documentation of Mr A's care could and should have been better in several respects. As Ms Rowe notes, registered nurses should document their own findings in the progress notes. Staff entering notes need to record their names and status legibly, record the times of entries, and ensure notes are not obscured by stamps. I agree that the separation of notes appears to be confusing for staff, with entries by care staff in the medical notes and entries by medical staff in the nursing notes. Ms Rowe also advises that more care should be taken with the type of information included in progress notes.

The clear and accurate documentation of a resident's condition and the care provided is not optional. It is a means by which relevant information is shared between those providing care and treatment, and is a key component of effective

teamwork. I am particularly concerned that some of the same documentation issues were highlighted in a previous investigation into care provided at the Village in September 2007, albeit within the hospital rather than the rest home.

The Village has noted that audit findings from the audit performed shortly before Mr A's death indicated that the criterion relating to daily progress notes was fully attained. Auditing documentation usually involves reviewing a sample of client files. It is quite possible for there to be differences between the standard of recording in an audited sample and that apparent in Mr A's record. My focus is necessarily on Mr A's records only. I remain of the view that on the basis of the deficiencies in Mr A's records, the Village needs to be more vigilant in relation to required standards of documentation.

Food and fluids
When the Village was advised that Mr A was dehydrated on admission to the public hospital, staff who had been involved in his care between Monday and Wednesday prior to Mr A's death were asked to note their recollections of what he had had to eat and drink during this period. There were some minor inconsistencies in their statements but I do not consider that these were an intentional attempt to mislead. The statements were made up to a week after the events, and no doubt staff would have found it difficult to recall accurately details of what and how much Mr A ate and drank. A food/fluid chart would certainly have helped, and would have been useful following Mr A's second fall.

It is noted that in the progress note entered on the day of Mr A's admission to the public hospital, Mr A did have breakfast and morning tea. This supports the view that it was during the course of that morning that Mr A's condition deteriorated significantly. It is impossible to determine when the dehydration began.

Care provided by enrolled nurses and caregivers
The enrolled nurses and caregivers worked under the guidance of registered nurses and, following Dr P's assessment, in accordance with his instructions. I accept Ms Rowe's advice that under these circumstances, the overall care provided by the enrolled nurses and health care assistants was reasonable.

Response to events and subsequent action
It is noted that following these events, the Village took prompt action, implementing a range of measures to improve the quality of the care provided at the Village and to minimise the likelihood of a similar event occurring again. The Village has worked with HealthCERT and the DHB to ensure timely action to address the concerns identified. This is to be commended.

Summary
It is acknowledged that even with adequate care, the outcome for Mr A may not have been different. It is also noted that the nursing advisors have concluded that the overall standard of care provided was acceptable for a rest home. Nonetheless, they also identified aspects of the care provided — including the response to Mr A's fall on the Tuesday before his death — that were not optimal.

Mr A was a rest home resident, and it was to be expected that his care would be provided for the most part by enrolled nurses and care assistants. However, Mr A was reviewed by two registered nurses following his fall on Tuesday (and seen informally by the clinical manager, another nurse). They assessed him as needing prompt medical care, if not hospital admission. This was Mr A's third fall that week. It was unwitnessed, resulted in a bleeding nose, and within a short time bruising was visible around his eye. There was a failure to arrange medical attention in a timely manner and to monitor his condition appropriately in the meantime. There were lapses in communication between staff and in the documentation of Mr A's condition and care.

For these reasons, I conclude that the Village failed to provide services to Mr A with reasonable care and skill, and that staff failed to communicate effectively with one another, and with Dr P, to ensure Mr A received quality and continuity of services. Accordingly, the Edmund Hillary Retirement Village breached Rights 4(1) and 4(5) of the Code.

Other matters — adverse comment

Individual staff were not the focus of this investigation, and I consider that primary responsibility for providing Mr A with co-ordinated, quality care lies with Edmund Hillary Retirement Village. I note that Ms Rowe is also of the view that "[The Village] needs to take responsibility for the level of assessment and care provided by their RNs". On reviewing the information about the nursing care provided following Mr A's fall on Tuesday, I am concerned about the deficiencies in relation to the care provided by RN Mr I. RN Mr I should have arranged prompt medical attention, if not by calling an ambulance then at least by contacting the after-hours GP service. His assessment of Mr A was incomplete and not well documented. These concerns have been followed up with RN Mr I.

Breach — Dr P

As GP expert Dr Kerse notes, Dr P cannot be held responsible for what he did not know. Mr A's risk of serious injury from a fall was increased by the fact that he had severe ankylosis of the spine, but this was not known until the day before he died. Dr P was not advised of Mr A's fall on Monday, and he was not alerted to the deterioration in his condition when he arrived at the Village on Wednesday.

However, Dr P had a duty to provide services with reasonable care and skill.[31] There was also a need for effective co-operation and communication.[32] For the

[31] Right 4(1) — Every consumer has the right to have services provided with reasonable care and skill.

reasons set out below, I do not consider the service provided to Mr A by Dr P was adequate.

PSA monitoring

Although the family's complaint was primarily about the care provided to Mr A over the three days prior to his death, it has become apparent in the course of this investigation that prior to this, there was a failure to monitor Mr A's PSA adequately.

Dr P has acknowledged that his plan to monitor Mr A's PSA levels monthly, as specified in December 2007, was not followed. The usual practice was for ward staff to record this in a ward diary. This arrangement failed, with Mr A having no PSA tests between 27 February and nearly six months later. I agree with Dr P that he must accept overall responsibility for this. It is noted that Dr P saw Mr A several times during this period, including three-monthly GP reviews in April and July 2008.

Dr P also advised that the oversight in prescribing Lucrin was a result of Mr A's records being filed at his surgery, where staff were unable to find them. The information provided suggests that Mr A's records were misfiled between October and December 2007, but that they had been located by 12 December 2007.

Dr P was contracted to provide GP services to other residents at the Village — enough to require that he routinely spent at least 5 hours there each week. I would be surprised if there were not other residents with conditions that needed to be regularly monitored with diagnostic testing. Dr P's arrangement with the Village for scheduling follow-up diagnostic tests should have been more robust.

Good clinical care includes providing or arranging investigations or treatment when needed.[33] I consider that Dr P's failure to take adequate steps to ensure this occurred represents a lack of reasonable care.

Assessment and treatment Tuesday

Dr P was not asked to see Mr A following his fall on Monday. Village staff first contacted Dr P at 8.40am on Tuesday, and he reviewed Mr A at about 1pm that day. This was a reasonable timeframe for a non-urgent request. Had a greater sense of urgency been conveyed, and had Dr P not been able to attend any earlier, Village staff would then have had the option of contacting the after-hours GP service or calling an ambulance. It was known by Village staff that non-urgent visits were usually made between midday and 2pm, or after 6pm.

I accept Dr Kerse's advice that Dr P's assessment of Mr A on Monday was adequate. His recording of this assessment was sparse, but information provided by Dr P subsequently indicates a more comprehensive assessment. EN Ms F's account

[32] Right 4(5) — Every consumer has the right to co-operation among providers to ensure quality and continuity of service.

[33] *Good Medical Practice: A Guide for Doctors* (Medical Council of New Zealand, June 2008).

of Dr P's assessment also points to a more thorough assessment than is evident from his notes. Dr Kerse considers that Dr P's treatment plan — for Mr A to be observed for a period and reviewed the following day — was appropriate. She states that the "[f]acial injury was noted and it is not unusual to observe such injuries". She adds that X-rays should be ordered only if they will alter the care plan.

Dr P informed staff that he would review Mr A the following day. No instructions were given in relation to monitoring Mr A's condition, including specific head injury monitoring. In addition, there is no evidence that consideration was given to Mr A's increased falls risk at this time. This was his second fall in two days, and his fourth fall within the month. While I accept that Dr P's assessment and treatment of Mr A on this occasion were adequate, I agree with Dr Kerse that the standard of care could have been improved if these matters had been addressed.

Assessment and treatment on Wednesday
Dr P arrived at the Village at 10am but did not see Mr A until 2pm. It appears that it was throughout the morning and early afternoon that Mr A's condition deteriorated significantly. However, Dr P was not advised of this, and cannot be held responsible for not having seen Mr A sooner.

The treatment plan following Dr P's visit to Mr A — for transfer to acute hospital care — was appropriate. Mr B may have been the first to mention the need for hospitalisation, but I accept that Dr P recognised the deterioration in Mr A's condition and the consequent need for hospital admission.

Ambulance transport
On Wednesday, Dr P identified that Mr A might have fractured a rib. He saw that Mr A was distressed and in pain, and that he was having difficulty moving. Ambulance transport was clearly required. If, as Dr P has suggested, his question to Mr B about taking his father to hospital was about the fact of hospitalisation rather than the mode of transport, this was not communicated clearly. Both Mr B and EN Ms F understood that Dr P was suggesting Mr B could take him in his car.

Dr P stated in his response that once it was agreed ambulance transport was required, there was "miscommunication" with regard to the priority of the ambulance. I am satisfied that it was Dr P with whom EN Ms F checked when asked about the priority of the ambulance. The transcript indicates that Dr P's request was for "low" or "no" priority, neither of which fits with his stated intention of 30 minutes. EN Ms F relayed this to the ambulance dispatcher as advised by Dr P. Although the ambulance dispatcher then suggested the ambulance would be there within the hour, this was an indication rather than a commitment. The ambulance in fact took one hour 24 minutes, but there had been nothing in the original request to suggest this might be problematic.

Documentation
Dr Kerse considers that Dr P's standard of recording was "inadequate to a mild degree". However, as she also notes, [the] "standard of medical note recording in rest homes is very variable, and the team approach of nursing and medical staff

requires a positive relationship and easy communication". I am not convinced that these elements existed at the Village.

Records are fundamental to patient care. They should include relevant clinical findings, decisions made, information given to patients, and any drugs or other treatment prescribed.[34] Dr P's records of his visits to Mr A do not support the level of assessment he subsequently advised he had undertaken. No treatment plan was documented following his visit on Tuesday. As the Commissioner has stated previously, "… records are an essential tool for patient management, for communicating with other doctors and health professionals, and for ensuring continuity of care".[35]

Summary

Dr P failed to ensure his systems for managing the care of patients who were resident at the Village were adequate. There were problems with the storage and retrieval of patient records at his surgery, and with his arrangement with the Village to ensure diagnostic testing was carried out as required. Consequently, Mr A's PSA was not monitored appropriately, and as Dr P had intended. There was a lack of due care in the service Dr P provided to Mr A and, accordingly, a breach of Right 4(1) of the Code.

Mr A's care was also compromised by a lack of co-operation between Dr P and Village staff to ensure quality and continuity of services. Dr P's intentions in relation to ambulance transport were not communicated clearly with Village staff or with family. His records of his consultations with Mr A were sparse and did not reflect a thorough assessment. In his response to this investigation, Dr P identified issues that had, in his previous experience, compromised the nursing care provided at the Village. While he may have considered these issues had been resolved by the time of these events, that experience would surely have reinforced the importance of ensuring his verbal and written communication was clear, thorough and unambiguous at all times. His failure to ensure this was a breach of Right 4(5) of the Code.

Naming

I have discretion to name group providers in the final version of any breach reports that are published on the HDC website and sent to relevant agencies. Each case is considered on its own merits. In this case, Edmund Hillary Retirement Village submitted that it would be inappropriate to publish its name in my report because it considers that the seriousness of the breach did not justify naming, and its interests would be unfairly compromised by any decision to name. I have carefully

[34] *Good Medical Practice: A Guide for Doctors* (Medical Council of New Zealand, June 2008).

[35] 06HDC12164 (29 February 2008).

considered this issue and decided that, on balance, the public interest favours publication. Accordingly, Edmund Hillary Retirement Village will be named in the version of this report published on the HDC website and sent to relevant agencies.

Recommendations

I recommend that the Village:

- provide a written apology to Mr A's family for its breach of the Code.

Dr P has provided a written apology to Mr A's family.

I recommend that Dr P:

- update HDC by **30 June 2010** on the changes made in relation to clinical documentation as a result of these events and following the audit of his rest home notes in October/November 2009.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, the Nursing Council of New Zealand, the District Health Board, and the Ministry of Health (HealthCERT).

- A copy of this report with details identifying the parties removed, except the names of Dr P, Edmund Hillary Retirement Village, and the experts who advised on this case, will be sent to the Royal New Zealand College of General Practitioners.

- A copy of this report with details identifying the parties removed, except the names of Edmund Hillary Retirement Village and the experts who advised on this case, will be sent to the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent advice from Registered Nurse Wendy Rowe

Independent Advisors Report

Complaint: [Mr A]
Our ref: 08/17309
May 2009

I have been asked to provide an opinion to the Commissioner on case number 08/17309. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am a registered nurse with 24 years of nursing experience. I spent the first 15 years of my career working in a hospital in a variety of settings, mainly medical and rehabilitation. I then worked for seven years in the private sector primarily in the aged care areas. My last job was as a senior Academic staff member at a polytechnic. I now work full time as a Clinical Nurse Manager of a convalescent care facility that is owned by a DHB, which includes hospital level care, slow stream rehabilitation, palliative care and GP admissions. I have a Bachelor of Nursing, a Master of Arts and a Certificate in Adult Teaching and Education. I am currently completing a postgraduate certificate in Adult and older Adult at Massey University.

Purpose:
To provide independent expert advice about whether Edmund Hillary Retirement Village provided an appropriate standard of care to [Mr A] in [late] 2008.

[Ms Rowe noted here a summary of the events and information she reviewed.]

Please comment generally on the standard of care provided to [Mr A] by Edmund Hillary Retirement Village

- The overall standard of care was adequate for a rest home setting (00349).
- Care delivered by the heath care assistants and enrolled nurse were appropriate.
- Care plans have no evaluation column.
- Blood sugar recordings were not evidenced.
- No recordings chart was given.
- The registered nurses need to document their actions in the progress notes instead of leaving it to others.

Please comment in particular on:

The adequacy of the response by nursing and care staff to [Mr A's] fall on [Monday]

- Appropriate level of care given on [Monday].
- Recordings would have been appropriate at this time (including sugar levels) and then ongoing monitoring for next 24 hours.

The adequacy of the nursing assessment following [Mr A's] fall on [Tuesday]

- RN [Mr I] completed baseline recordings but no blood pressure or blood sugars and did not record findings in the progress notes.
- The incident form had more information on it than was documented in the progress notes.
- At 0840 EN [Ms F] took further recordings but no blood pressure and noted sluggish pupils, (00287) but did not indicate to the RN [Ms J] that the client required review as soon as the GP arrived. There was no ongoing monitoring by the registered nurses (00285).

The decision by nursing staff to await a GP review rather than arranging for an out of hours doctor visit or sending [Mr A] to hospital, after his fall on [Tuesday]

- The decision about transfer to hospital for review needed to be determined by RN [Mr I] as he completed the assessment of [Mr A] at 0600 hours.
- The progress notes do not show us the level of assessment completed by RN [Mr I] as being appropriate although there is more information in the statement.
- Review by a medical practitioner at this time would have been appropriate. A client should not be the one who makes this decision.

The adequacy of the care provided by nursing and care staff following [Mr A's] fall on [Tuesday]

- Ongoing monitoring of [Mr A] would have shown a clearer picture of events as he deteriorated over the next 24 hours.
- The enrolled nurses and health care assistants gave an adequate level of care. A registered nurses' review would have been appropriate.

Whether [Mr A's] food and fluid intake was monitored satisfactorily from [Monday to Wednesday]

- There is sufficient evidence to indicate [Mr A's] food and fluid intake was appropriate between these dates.
- At times he refused meals, but there is evidence to suggest he also ate meals.
- The morning of his transfer to hospital there is evidence he ate breakfast.
- Exact amounts eaten could only be determined with a food/fluid diary.
- [Mr A's] level of pain during this period of time may have contributed to a decrease in food and fluid intake and a level of dehydration noted on admission to hospital.

The adequacy of the documentation by nursing and care staff [during the month prior to Mr A's death]

- Health care assistants generally complete documentation at rest home level.
- Entries by the registered nurse in this case are poor as they lack clarity and ongoing planning.
- Stamps placed over individual entries or signatures are confusing.
- Segregated progress notes lead to confusion.
- Times of entries need to be improved, along with legible name and status recorded accurately.

Whether EHRV responded appropriately to [Mr A's] [three falls prior to the fall on Monday]

These falls were appropriately managed and were not significant in nature.

Please comment on the response provided to HDC by EHRV, including the response to RN Baker's preliminary nursing advice.

- Report from RN Baker is comprehensive. I agree the care was appropriate and that following the fall on [Tuesday] transfer to hospital may have been the best option. I also agree there is some room for improvement with documentation. The use of the two phrases "knocked out" and "significant head injury" have been noted by [the Village]. These two phrases seem to have caused some issues.
- Report from EHRV show an extensive investigation process has occurred. RN [Mr I] did assess [Mr A] at the time of his fall on [Tuesday], however did not document in the progress notes. A more thorough assessment may have led the RN to transfer the client to hospital. This was an oversight. RN [Ms J] also had the opportunity to insist on a general practitioner review at 0830 on [Tuesday] or transfer to hospital. It is the responsibility of the RN to make decisions about a client's level of need and when to insist on further assessment. [The Village] needs to take responsibility for the level of assessment and care provided by their RNs.

Please comment on the changes implemented by EHRV since these events.

- All changes implemented since this event show significant improvements.

I will not comment on [Dr P].

Are there any aspects of the care provided by Edmund Hillary Retirement Village that you consider warrant additional comment?

New falls management processes will ensure better client outcomes. Appropriate steps have been taken to ensure clients remain safe. All staff need to be encouraged to document at an appropriate level and in a chronological order (this needs to include the GP and allied health staff) to ensure there is a transparent picture of all events. Staff should be reminded that the progress notes are a legal document and it is therefore inappropriate to record daily tasks like bed changes. Significant events and changes to plan of care need to be documented (in a legible manner). When a registered nurse assesses a client they should record their own findings and plan for ongoing monitoring accurately. In my opinion the conduct of the registered nurses caring for [Mr A] were of moderate disapproval following the fall on [Tuesday] and may not have changed the outcome for [Mr A]. Systems have now been implemented to ensure a more robust process occurs in the future.

Thank you
Wendy Rowe (MA,BN,RN,CATE).

RN Rowe was subsequently asked to provide further comment in relation to the responsibilities of nursing staff to seek medical advice, and to respect [Mr A's] wishes.

7 October 2009
Thank you for the opportunity to review this aspect of this case. I have read the information sent to me via email. I believe that the registered nurse who assessed [Mr A] at 0600 hours should have sought further advice as this was an unwitnessed fall. The assessment by the nurse at this time as I have already mentioned was inadequate and not complete. Communication was poor between the staff and the documentation re the ongoing monitoring was inadequate. Residents do have rights, however it is the registered nurses' responsibility to keep the patient safe. A phone call to the general practitioner or the on call doctor may have indicated to the registered nurse what monitoring was required until such time that the resident could have been fully assessed. Although [Mr A] clearly articulated he did not wish to go to hospital the registered nurse should have sought an assessment. [Mr A], following assessment, may have still chosen to stay within the facility. Assessment is not the same as transfer to hospital. The issue here is not about patients' rights but assessment, therefore there should be no dispute.

RN Rowe was also asked to review Professor Wilkinson's comments.

7 December 2009
Thank you for the opportunity to further review this complaint. I have reviewed my advice, Professor Wilkinson's original report and his further comments. I do not wish to change any statements I have already made. I will not be commenting on Professor Kerse's report as I have not read it. I agree that rest home residents' autonomy should be respected and that they should be involved in decision making.

I believe that the issue here is not about the risk of falling, but how the fall on [Tuesday] was managed by the registered nurses. There was a lack of assessment and ongoing monitoring by the registered nurse at 0700 and 0840. Registered nurses need to be able to fully assess a patient who has had an unwitnessed fall and document adequately in the clinical records. I reiterate the issue here is not patients' rights but assessment. [Mr A] was indeed attended to promptly by the nursing staff following the fall on [Tuesday morning] but not adequately assessed. The general practitioner was contacted and came at 1pm to see the patient. Had the registered nurses accurately assessed the patient and sought further advice from the general practitioner based on their comprehensive assessment the outcome may have been transfer to hospital for further assessment, or some ongoing monitoring until the general practitioner arrived. This may not have changed the outcome for the patient.

Appendix B — Independent advice from Dr Ngaire Kerse

The following preliminary expert advice was obtained from general practitioner Dr Ngaire Kerse.

Thank you for your request of 9 December 2008 to provide "Preliminary Expert Advice" in relation to a complaint received about the Edmund Hillary Retirement Village/Dr P, Ref 08/17309. I am asked to provide advice on the standard of care provided to [Mr A] by [Dr P]. I may also comment on any systems or organizational issues.

I have read and taken note of the guidelines for advisors. I have an MBChB (Otago) 1984, completed a fellowship in Geriatric Medicine at the University of Pennsylvania 1989–91), PhD (Melbourne) 1998 and have the fellowship of both the New Zealand (1999) and Australian Royal College of General Practitioners (1997) having been board certified in family practice 1986–1993 in the USA. I run a programme of research in gerontology at the University of Auckland including working (research) in over 40 aged residential care homes in Auckland and Christchurch and have provided general practice services to older people in three residential care facilities in Auckland for 5 years and overseas for an additional 3 years.

I base my opinion on the following facts from the records provided by the office of the HDC.

[Dr Kerse noted here key facts from the information she reviewed.]

The medical care offered and delivered by [Dr P].
I have been asked to give my opinion as to whether the medical care given by [Dr P] was appropriate or of a lower standard than acceptable to a minor or major degree.

[Mr A] was cared for at the Edmund Hillary Retirement Village in the rest home. I assume he was in the rest home from the records and reports of the nursing staff. He was previously independent with reasonable cognition and managing quite well. [During the month prior to his death] he sustained 5 falls, initially without sign of injury and then after being found on the floor in the bathroom at 0600 on [Tuesday] appears to have sustained significant injury.

[Dr P] attended [Mr A] on [Tuesday]. The request was placed in the morning and he attended at lunch time. This is acceptable and usual practice especially as there was no evidence of urgency in the request as typed into the GP record. The GP note was brief, indicating no bony injury and other relevant findings. An ACC claim was instigated. There was no note as to desired frequency of monitoring or special cares wrt [with regard to] a head injury or any particular falls prevention initiatives. The reason for the increased falls was proposed to be related to the prostate cancer treatment administered by injection 2 weeks before. The nursing notes record vital signs on [Tuesday] with increased BP and fast heart rate which settled a little.

The standard of recording is not excellent but adequate. The amount of unrecorded verbal communication between doctor and nurse and hand over of instructions is not known. It would be reasonable to expect regular monitoring after such a fall where there is obvious head trauma. Standard of medical note recording in rest homes is very variable and the team approach of nursing and medical staff requires a positive relationship and easy communication. The standard of care on this occasion was reasonable and could have been improved if consideration of specific head injury monitoring, attention to recent recurrent falls, and ongoing falls prevention strategies was included.

[Dr P] visited again the next day and saw [Mr A] in the early afternoon at which time [Mr A] appeared to be deteriorating rapidly. This deterioration is not well appreciated from the records and there are contradictory reports of fluid and food intake and mental status. The way, or whether at all this was communicated to the doctor is unknown. It is not clear to me who instigated the hospitalizations. [Dr P] reports in his letter that he had clearly decided to admit [Mr A] before the son suggested it, this is corroborated by at least one nurses report, and is refuted by the son.

The delay in transfer to hospital is less than ideal, however [Dr P] stated that he thought the ambulance was priority 2 but perhaps had failed to communicate this. The medical note on [Wednesday] is brief and communicates the change in clinical status and the need for transfer to hospital. The standard of recording and standard of care by [Dr P] are reasonable in my opinion. The situation is complicated by the rapidity of the decline in [Mr A's] health and the apparent contradictory records and lack of direct communication with [Dr P] about the patient's changing status.

From the medical and nursing records it would be quite reasonable to observe the patient for a period after a fall and then ensure reassessment occurs. In this case the reassessment indicated the need for admission to the acute public hospital and transfer was arranged. The fractures were not noted the day of the fall perhaps due to a combination of patient resilience in denying pain (on and off) the subacute nature of the deterioration (more than 24 hours after the fall event).

This concludes my opinion. The following comments are more general in nature and may not be relevant to the request you have made of me. Please disregard them if that is the case.

Falls are very common in residential care [1] and the consequences of them can be drastic as in [Mr A's] case. Preventing falls is possible [2] but requires commitment from all staff and considerable additional resources such as more physiotherapy input and more specialist geriatric medicine input. As yet there are some falls prevention activities in residential care but on the whole routine post fall medical evaluations and specific upskilling about falls for the whole team is not as yet at an ideal standard. There is a large capacity in primary nursing and medical residential aged care for increased knowledge and practice related to management of falls.

Rest homes have a lower capacity to deliver high levels of care than other settings, especially in the area of registered nursing hours. There are usually many residents

and tasks that a nurse and health care assistant is needed for and perhaps with a higher level of capacity for care, those with recent changes in their health and recent injury could be more closely monitored. In [Mr A's] case there could have been closer monitoring of his deterioration and more urgent communications between care assistants, nurses and the doctor and a clearer communication of the need for urgent transport. It is also concerning that in the public hospital sector [Mr A] "acquired" the diagnosis of dementia when he clearly had a background of high level functioning and pretty good cognition according to the record anyway. He was clearly very unwell and probably suffering from delirium related to respiratory compromise, (probably as a result of the injury, plus the positioning necessary for treatment and his underlying vocal cord problems) rather than dementia. A clear appreciation of his baseline status may have altered the level of therapy offered by the hospital staff.

Yours sincerely
Ngaire Kerse PhD, FRNZCGP, MBChB General Practitioner

1. Kerse N, Butler M, Robinson E, Todd M. Wearing slippers, falls and injury in residential care. Australian and New Zealand Journal of Public Health. 2004; 28:l80–7.
2. Gillespie L, Gillespie W, Robertson M, Lamb S, Cumming R, Rowe B. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev. 2003;4:CD000340, (recently updated).

Further advice from Dr Kerse

Dr Kerse was subsequently asked to consider additional information received after the commencement of this investigation, and to review her preliminary advice in light of this.

Additional advice
Thank you for your request of 6 May 2009 to provide "Expert Advice" in relation to a complaint received about the Edmund Hillary retirement Village/[Dr P], Ref 08/17309. I am asked to provide advice on the standard of care provided to [Mr A] by [Dr P]. I respond to your specific requests for comment on the points listed in your document Medical/professional Expert Advice in order of their appearance. I have reviewed the new documents sent with your request and my previous report with parts of the medical records as appropriate.

The medical care offered and delivered by [Dr P].

I have been asked to give my opinion as to the general standard of care given by [Dr P] during 2007–2008.

I maintain my view as expressed in the preliminary advice:

That the general care of [Mr A] after the falls was adequate, the delay in transfer to hospital unfortunate and a result of miscommunication. The amount of detail in the assessment after the falls is unclear, but I have to give [Dr P] the benefit of the

doubt after reading his response. It appears that [Dr P] did complete thorough assessments but did not document them adequately. The level of documentation was not appropriate to a **mild** degree, and [Dr P] has attested to improvements.

Your specific points to comment on follow.

2) a. monitoring of the PSA level. I could not find this in my initial review of the detailed case notes. Your complaint notes that there were no PSA tests from February till August 2008. This is an oversight on [Dr P's] part. It should be a team approach to care and systems of routine testing are usually set up between the nursing and medical staff. No such system seemed to be in place. This is a departure from an appropriate level of care to a **moderate** degree. [Dr P] notes that these requests are usually put in the ward diary, but were not on this occasion. This is a failure of a system of care, but [Dr P] does bear some responsibility for it. Overlooking this testing regime may or may not have had an impact on the recurrence of falls. In fact the falls may have happened earlier if they were in fact linked to the lucrin administration and the injections had been restarted earlier.

b. the standard of assessments on [Monday and Tuesday]. As recorded in the rest home record, these could have been considered scanty, however, [Dr P's] response and the nursing response indicate that there was a careful examination on both occasions, and that the change in status was noted and acted upon. I consider the assessment to be adequate care.

c. the treatment plan was also appropriate on both occasions. Facial injury was noted and it is not unusual to observe such injuries and XRays should only be ordered if they will alter the care plan. On the revisit on [Tuesday] the clinical deterioration with drowsiness and suspected head injury necessitated admission to hospital, and this was arranged.

d. as noted above the standard of documentation was inadequate to a **mild** degree.

e. the adequacy of communication between [Dr P] and the staff is largely unknown. This is key to care when there are several people caring for frail elders over time. Both the Dr and the nursing staff report good communication. The lack of appreciation of the urgency of the second visit on [Tuesday] is a concern, but [Dr P] cannot be held responsible for what he does not know.

f. The changes suggested by [Dr P] to his practice are reasonable and if sustained will result in improvements in the systems of care at EHRV and in [Dr P's] processes.

3. I had not noted that the PSA tests had been overlooked and this is an alteration to my preliminary advice.

4. I have no further comment.

Yours sincerely
Ngaire Kerse PhD, FRNZCGP, MBChB, General Practitioner

Appendix C — Edmund Hillary Retirement Village's Falls Policy effective in September 2008

document revision

Restore this revision Revision List

Revision 1.3 for Content field in Document

All staff are to be aware of fall prevention practices to reduce the risk that a resident may fall. This may include but not be limited to:

- assessment of the resident's physical mobility and transfer requirements
- programmes that promote safe mobility and transfers
- the removal of hazards that could cause falls
- the provision of equipment such as hoists and relevant aids as required to meet the service specification related to this facility or if prescribed by a physiotherapist, occupational therapist or medical practitioner.

Please refer to {reference document=54 name="Accidents: Prevention Of"}.

In the case of a resident falling the following actions are to be followed:

If a Registered Nurse is on duty, she should be called before the resident is moved

1. If the resident falls, do not move the resident, check for injury and reassure. If no injury apparent assist into sitting position after a few minutes, assist to feet or onto a wheelchair.
    1. {attachment name="Incident Report Form" id="I 7' mode completed and detailed
    2. Documentation of the incident entered into {attachment name="Progress Notes" id"108" mode="link"}.
    3. Take baseline observations
2. If the resident is knocked out briefly or has hit their head, notify resident's GP or After Hours Doctors. Do not move the resident but keep comfortable and warm on the floor. Observations are as follows:
    1. Blood Pressure
    2. Pulse
    3. Pupils and reaction to light
    4. Level of Consciousness, orientated to time and place, responding to voice
    5. Hand Grips, equal both sides
    6. Leg Movements, equal on both sides
    7. Notify Registered Nurse on call
    8. Next of kin to be notified
3. Continue observations at 30 minute intervals until seen by a Medical Officer for further instruction.
4. If the resident is unconscious and remains so, an ambulance is called. Do not move the resident. Keep warm and safe on the floor. Check the following:
    1. ABC (airway, breathing, colour)
    2. Pupils equal and reacting to light
    3. Pulse
    4. Level of consciousness, responding to voice are taken immediately and at 30 minute intervals. A caregiver remains with the resident until the ambulance officers take over.
    5. Notify next of kin

Remember to fill out an {attachment name="Incident Report Form" id="17" mode="link"} and document the event in the resident's {attachment name="Progress Notes" id="I 08' mode="link"}.

The Manager is responsible for analysing the cause of resident falls. Please refer to {reference document=259 name="Incident Reporting"). Should a resident be falling regularly, this is to be brought to the attention of relatives, GP, etc. and a medical multidisciplinary review undertaken. If the resident's {attachment name="Coombe Assessment for Predicting Fall Risk" id="58" mode='link"} on admission or care plan review did not identify a falls risk, please reassess the resident using the {attachment name="Coombe Assessment for Predicting Fall Risk" id="58" mode="link"}.