Heritage Lifecare Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01406)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by Heritage Lifecare Limited (trading as Waiapu House Lifecare (WHL)). The woman was a resident at WHL during a period of staff turnover and managerial change, and it was Heritage Lifecare Limited's responsibility to ensure continuous care for the woman during this time. The systemic issues resulted in appropriate assessment and interventions not being actioned for the woman to manage her pain and end-of-life cares.

2. The report highlights the importance of providers managing periods of organisational change to ensure that services continue to be provided with reasonable care and skill.

Findings

3. The Deputy Commissioner found Heritage Lifecare Limited in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that the woman's Lifestyle Care Plan was written belatedly and not adopted into her daily cares to manage pain; the mandatory interRAI assessment was not initiated; and a Last Days of Life Care Plan was not initiated.

4. The Deputy Commissioner made adverse comments about the Clinical Services Manager and Acting Clinical Services Manager, in particular that neither manager provided the support and guidance needed to ensure that the woman's mandatory interRAI assessment was completed.

Recommendations

5. The Deputy Commissioner recommended that Heritage Lifecare Limited undertake regular clinical documentation audits; undertake a quality improvement initiative on the use of assessments and care plans; schedule regular and ongoing education sessions for nursing staff on pain management and end-of-life care; use an anonymised version of this report as a case study; update the Allocation of Staff/Duty Rosters policy; and provide a formal written apology to the family.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Heritage Lifecare Limited (trading as Waiapu House Lifecare), to her mother, Mrs B. The following issue was identified for investigation:

- *Whether Heritage Lifecare Limited, trading as Waiapu House Lifecare, provided Mrs B with an appropriate standard of care between Month2[1] and Month4 2018 (inclusive).*

[1] Relevant months are referred to as Months 1–4 to protect privacy.

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

8. The parties directly involved in the investigation were:

Ms A	Complainant/consumer's daughter
Heritage Lifecare Limited (Waiapu House Lifecare)	Provider

9. Further information was received from:

Registered Nurse (RN) C	Waiapu House Lifecare (WHL)
Facility Manager (WHL)	
Care Home & Village Manager (WHL)	
RN D	Acting Clinical Services Manager (WHL)
RN E	Clinical Services Manager (WHL)
Dr F	General practitioner (GP)
District health board	
Hospice	Provider
HealthCERT	

10. In-house clinical advice was obtained from RN Hilda Johnson-Bogaerts (Appendix A).

Information gathered during investigation

Introduction

Mrs B

11. Mrs B, aged in her nineties at the time of events, had recurrent pneumonia,[2] chronic lymphocytic leukaemia,[3] Parkinson's disease,[4] and a sacral pressure injury.[5] On 18 Month2, Mrs B was admitted to WHL from the district health board (DHB) for respite care. On 14 Month3, she was reviewed by a consultant physician/geriatrician at the DHB. Mrs B became a permanent resident of WHL and required hospital-level care until her death on 21 Month4.

12. Mrs B required full assistance with daily living activities, and previously had been under the care of hospice. Dr F had been Mrs B's GP in the community for over 20 years, and provided GP reviews of Mrs B at WHL. Mrs B's son held an enduring power of attorney (EPOA) for Mrs B for personal care and welfare and property.

[2] An infection of the lung(s).
[3] Cancer that affects white blood cells.
[4] A disorder of the central nervous system that affects movement.
[5] A skin wound in the lower back area between the two hip bones.

13. This report concerns the care Mrs B received at WHL from Month2 to Month4, in particular assessments and care planning, including the interRAI assessment, the Last Days of Life Care Plan and the Lifestyle Care Plan, and the management of Mrs B's pain and pressure injuries.

Waiapu House

14. WHL provided rest-home and hospital-level care for up to 74 residents. The service was operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager.

Clinical Services Manager

15. RN E was the Clinical Services Manager (CSM) to 2 Month4, when she ceased employment with WHL.

16. RN D was the Acting CSM from 5 Month4, becoming permanent in this role later that year.

17. The CSM reported to the Facility Manager and was responsible for providing high-level clinical leadership and support to clinical staff and care staff.

Contact with Dr F

18. During Mrs B's stay at WHL from 18 Month2 to 21 Month4, nursing staff communicated with Mrs B's GP, Dr F, on a number of occasions, including for GP reviews and pain medication management.

Contact with the hospice

19. Prior to Mrs B's admission to WHL on 18 Month2, on 12 Month1, after 11 weeks in hospital with recurrent pneumonia and delirium, Dr F had referred Mrs B to the hospice for symptom management and support.

20. During her stay at WHL, a hospice nurse visited Mrs B on 22 Month2, 30 Month2, 13 Month3, and 6 Month4. WHL told HDC: "[The] Hospice did not identify any concerns to us about pain management."

Pressure injury management

21. On her admission to WHL, Mrs B had a stage 2[6] sacral pressure injury. A pressure area assessment was initiated on 18 Month2 and revisited on 8 and 18 Month4. A wound assessment form, a short-term care plan, and a pain assessment were completed on 18 Month2, and a wound monitoring form was commenced. The pain assessment identified the cause of Mrs B's pain to be "pressure on [her] bottom".

22. Pressure injury prevention strategies used for Mrs B included an air mattress, regular position changes, and regular dressing changes. The Repositioning and Skin Inspection Charts show that these interventions were maintained during Mrs B's stay.

[6] The skin breaks open, wears away, or forms an ulcer, which is usually tender and painful. The sore expands into deeper layers of the skin.

23. Ms A told HDC:

> "Mum was supposed to be on an air mattress due to her pressure sore — it took Waiapu House 3 days to get Mum onto one which was working properly. Also at one stage the air mattress was over inflated, and it took a while before a nurse noticed and rectified that problem. Mum was also not turned when she should have been, and this made her pressure sore wound worsen considerably."

24. WHL alerted Dr F to Mrs B's sacral wound, and corresponded with her on 25 Month2, 26 Month3, 6 Month4, and 12 Month4, with a specific request to review the pressure injury on 12 Month4.

25. On 5 Month3, Mrs B's wound was reassessed as being a stage 4 pressure injury, and HealthCERT[7] was notified, an incident form was completed, and the wound was discussed with Mrs B's family.

26. On 28 Month3, Dr F ordered a swab of the wound, which showed the presence of MRSA.[8] The recommended management was good wound care (antibiotic therapy is not recommended routinely). A referral was made to the Wound Nurse Specialist on 1 Month4. On 6 Month4, Dr F reviewed Mrs B, and on 7 Month4 oxycodone[9] was commenced via syringe driver.

27. On 8 Month4, the sacral pressure injury had deteriorated and was assessed as unstageable.[10] The wound management plan was updated, and the injury was discussed with the family. Photos of the sacral pressure injury were taken over time to record the deterioration.

28. Ms A told HDC:

> "Mum had a bedsore which had developed at the end of her first week in [the public hospital], which had been managed in hospital and then by us in her own home, and then in Waiapu it became huge. I was told that they were just looking after Mum and keeping her comfortable, and if she went back into [the DHB] she could have the bedsore treated. I felt totally let down as I had thought by placing Mum in their care she would get better treatment and care than we could give her at home."

29. On 12 Month4, the sacral wound was reviewed by the Wound Nurse Specialist, and the wound management plan was updated. A short-term care plan was developed for

[7] HealthCERT at the Ministry of Health is responsible for ensuring that hospitals, rest homes, residential disability care facilities, and fertility providers provide safe and reasonable levels of service for consumers.
[8] Methicillin-resistant *Staphylococcus aureus*, a type of bacteria that is resistant to several antibiotics.
[9] An opioid medication used for treatment of moderate to severe pain.
[10] Full thickness tissue loss in which the base of the ulcer is covered by slough or eschar.

"[d]eterioration in health status" and "compromised skin integrity". A fax was sent to Dr F requesting metronidazole[11] gel, and this was used from 14 Month4.

30. The family/whānau communication record shows that on 13 Month4 Mrs B's wound management was discussed with Mrs B's son and attorney under her EPOA. The record states: "[Mrs B's son] informed me that [Mrs B] is not for active treatment for her sacrum wound [and] for this to be managed within the facility." There was further communication with Mrs B's family on 19 and 21 Month4 regarding the deterioration and management of her sacral wound.

31. In addition to the sacral wound, from 9 Month4 Mrs B developed a new wound on her heel and skin tears on her elbow, hand, and upper arm. Wound Assessment forms and Soft Tissue Care Plans were initiated. WHL told HDC:

> "Pressure area care was maintained to reduce weight on broken/susceptible areas thereby reducing the risk of pain. This included the use of an air mattress, regular repositioning, elevation of limbs, [S]penco heel protectors and leg protectors."

Pain management

Pharmaceutical interventions and GP review

32. The Pain Assessment and Management Policy and Procedure states that "[p]ain is assessed as part of the interRAI assessment" with additional pain assessment tools to be used, such as on admission "[f]or residents where pain is a significant presenting issue".

33. A Pain Assessment was completed for Mrs B on her admission to WHL on 18 Month2. On 7 Month3, a pain monitoring chart was initiated, and reviews of her pain were recorded daily. The pharmaceutical interventions taken, and the effects of these, were documented.

34. PRN[12] midazolam,[13] quetiapine,[14] and oxycodone were prescribed from 18 Month2, and PRN paracetamol from 23 Month2.

35. The nurses at WHL faxed Mrs B's GP, Dr F, a number of times requesting pain medication reviews. On 25 Month2, Mrs B was experiencing low mood, feeling agitated, and refusing medications and meals. On this occasion, a locum GP visited and reviewed the medication regimen. On 2 Month3, Mrs B experienced increased levels of pain, and Dr F prescribed further pain medication.

36. Dr F reviewed Mrs B on 7 Month3, 6 Month4, 12 Month4, and 21 Month4. On 7 Month3, Dr F visited and recommended continuing with the current pain relief. WHL nurses contacted Dr F on 11 and 14 Month3 regarding sore eyes and constipation. On 26 Month3, nursing

[11] An antiprotozoal and anaerobic antibacterial agent.
[12] Pro re nata, as needed.
[13] A medication used for sedation, sleep, and severe agitation.
[14] A medication used for mood conditions.

staff informed Dr F that pain medication was having little effect, and Dr F prescribed extra paracetamol.

37. On 6 Month4, Mrs B had increased pain and refused food and fluids. Dr F reviewed Mrs B, and a syringe driver with oxycodone and midazolam was started on 7 Month4. This was discussed with Mrs B's son.

38. Further correspondence was sent by WHL to Dr F on 19 and 20 Month4 requesting a review and referring to "unmanageable pain". Dr F increased the prescription for pain relief on 19 Month4, and visited on 21 Month4. The family/whānau communication record shows that on 19 Month4 Mrs B's son was informed of "medication changes to S/D + continuing to monitor pain levels" and that Mrs B's son "voiced nil concerns".

39. The dose of oxycodone was gradually increased[15] from 2mg per 24 hours on 7 Month4 to 12mg per 24 hours on 18 Month4. On 19 Month4, WHL requested a further review of Mrs B's pain relief, and Dr F increased the prescription of oxycodone to 20–25mg per 24 hours. Mrs B was administered 20mg on 19 Month4, and 25mg on 20 Month4.

40. Dr F told HDC that the use and dosage of opiates she prescribed reflected that Mrs B was "in her 90s, deconditioned, was cachexic and underweight, renally impaired and had a recent delirium. The oxycodone oral solution was prescribed for palliation of shortness of breath." Dr F commented that the regular background analgesia with oxycodone was "primarily for aiding with comfort for her cares and breakthrough pain". Dr F stated that administration via a syringe driver commenced on 7 Month4 "for pain but also because [Mrs B] was having difficulty with oral medication and she was entering a terminal phase".

Lifestyle care planning (non-pharmaceutical interventions)

41. In her complaint, Ms A expressed concerns that Mrs B spent the last eight weeks of her life in pain.

42. The Pain Assessment and Management Policy and Procedure states that "[r]esidents will be provided with individualised pain relief plans with the aim of preventing unrelieved pain". The policy also states that "[p]ain management should be individualised and is often a blend of pharmacological and non pharmacological approaches".

43. The Handover Diary reminded staff to sit Mrs B in her recliner chair to attend activities. On 23 Month3, staff reviewed Mrs B's activity plan and noted that often Mrs B was in a lot of pain but did not like being in her room all the time, and had expressed a desire to join in some activities. Time management was important, as she "got uncomfortable quickly in [her] chair".

44. The activity plan was reviewed again on 7 Month4, and documented:

[15] 2mg per 24 hours on 7 Month4, to 4mg on 8 Month4, 5mg on 9 Month4, 6mg on 12 Month4, 8mg on 16 Month4, to 12mg per 24 hours on 18 Month4.

> "[Mrs B is] not happy to be left in her room all the time … so an effort must be made to give [Mrs B] 1:1 time, and when she is in [a] wheelchair give her some brief stimulation before [the] pain [becomes] too intense."

45. RN E ceased her employment with WHL on 2 Month4, and RN D became the Acting Clinical Manager from 5 Month4. RN D told HDC that she reviewed Mrs B's clinical records on 8 Month4 and noted that she did not have a Lifestyle Care Plan. RN D then belatedly completed the Lifestyle Care Plan for Mrs B that day, and some additions were made on 18 Month4. The Plan discussed interventions, care, and goals for Mrs B.

46. RN D told HDC:

> "[Mrs B's] [Lifestyle Care Plan] incorporated her values and needs. I clearly indicated throughout the [Lifestyle Care Plan] [Mrs B's] Nursing Diagnosis, goals and interventions at the time. This included the use of non-pharmaceutical interventions ie: participation in activities, music, family time, one on one and time with our Chaplain."

47. WHL told HDC:

> "The Lifestyle Care Plan (written on 8 Month4) identified non-pharmaceutical interventions to assist with management of pain/agitation however, there is only one entry stating music was playing in [Mrs B's] room. There is no evidence that any other non-pharmaceutical therapies were considered or implemented to manage [Mrs B's] pain."

Staffing levels

48. Ms A told HDC:

> "We discovered that the staffing level was not good, in that when Mum needed something she would often wait for over half an hour until someone came. After 20 to 30 minutes I would go looking for some care staff to assist Mum, or a nurse when she was in bad pain.
>
> My brother and sister-in-law waited with Mum for an hour and a half for a nurse to come and give some more medication to relieve her pain. An hour and a half!! It turned out that there was not enough nursing staff rostered on to be able to oversee the medication."

49. The Allocation of Staff/Duty Rosters policy states that "[a] base roster showing staff designation and hours will be set according to the needs of the client groups, individuals and numbers", and that "[t]here will be sufficient staff at all times to meet the assessed needs of the residents". The policy also states that "when specific needs indicate, an increase in staff levels may be required".

50. In August 2019, WHL told HDC that the staffing rosters for the period Month2 to Month4 were reviewed, and that WHL was operating in accordance with the Ministry of Health Minimum Staffing Guidelines for Aged Care. These staffing rosters were provided to HDC.

51. In response to the provisional opinion, RN E commented that there was high turnover of staff and "burn out" from nurses. RN E told HDC: "We tried but were unable at the time to recruit agency nurses to allow time off the floor."

52. In response to the provisional opinion, WHL told HDC that it "does not accept that there was ever insufficient time for registered nurses to complete their interRAI assessments and care planning. WHL stated that it "is firm in its view that it has never had insufficient staffing at Waiapu House". WHL told HDC that Heritage acquired the Waiapu House facility in mid-2017, and stated:

> "[T]he previous facility had been overstaffed in a way that was simply not viable to operate. Heritage did regularise the rostering of staffing, but at all times it has been in excess of Ministry of Health mandated standards."

53. WHL acknowledged that at times it was difficult to recruit agency nurses, and said that this is an ongoing difficulty across the sector. To maintain appropriate staffing, nurses' shifts are extended, or staff like RN E assist with care.

54. RN C told HDC:

> "There was high staff turnover at WHL during the time I worked there including RNs, managerial changes and a reduction in the number of Healthcare Assistants (HCAs). This meant a heavy workload for the RNs and resulted in many of the residents' lifestyle care plans and other assessments becoming overdue."

55. RN C stated: "Due to the lack of staffing I rarely had breaks, including lunch breaks, while I worked at WHL."

56. The Primary Care Directorate at the DHB told HDC: "[A]round the time of [Month2] to [Month4], it was known that Waiapu House were actively recruiting and the managers were working to maintain staff/patient ratios."

interRAI assessment

57. The interRAI Long Term Care Facilities (LTCF) Assessment Tool is the mandatory primary assessment tool for long-term residential aged care in New Zealand. The interRAI LTCF is to be used to assess residents' needs and inform residents' care plans. The assessment should have been completed within 21 days of Mrs B's admission as a permanent resident, ie, by 3 Month4. However, no interRAI assessment was initiated for Mrs B.

58. WHL told HDC that RN E was the senior person primarily responsible for ensuring that the interRAI assessment was completed. WHL told HDC:

> "It is unclear why [RN E] or the RN's failed to ensure these assessments were completed despite there being six [i]nterRAI trained RN's employed at the time. The Facility Manager had rostered RN's 'interRAI shifts' to allocate dedicated time for these primary assessments to be completed."

59. In response to the provisional opinion, RN E told HDC that she kept spreadsheets of the due dates of all the care plans, interRAI assessments, wound assessments, and short-term care plans, including who was responsible for their completion. RN E stated that Mrs B's interRAI assessment was not mentioned in her handover document, as "it wasn't red flagged yet", but added that "the due date would have been evident for the next clinical manager to easily identify". As context, RN E described working as a carer to ensure that residents had appropriate provision of care, working long hours to prepare for an audit, increased occupancy, and recruiting for care assistants. RN E told HDC that she did request support from her seniors at this time. WHL told HDC that it provided additional assistance through transferring RN D to assist.

60. On 2 Month4, RN E ceased her employment with WHL, and RN D was appointed as the Acting CSM from 5 Month4. WHL told HDC:

> "In her first week as [Acting CSM], [RN D] reviewed [Mrs B's] clinical file. [RN D] noted that the interRAI assessment had not been completed and the Lifestyle Care Plan had not been written … [RN D] was not granted access to Waiapu House [i]nterRAI at this time and regretfully [Mrs B's] interRAI assessment was never completed."

61. In Month4, RN C[16] was the nurse allocated to complete Mrs B's interRAI assessment.

62. RN C told HDC that around November 2017 the CSM introduced registered nurses having "primary residents". RN C described "high staff turnover at WHL" and commented that "this meant a heavy workload for the RNs and resulted in many of the residents' lifestyle care plans and other assessments becoming overdue". RN C acknowledged that "[i]nterRAI assessments are ideally completed prior to Lifestyle care plans in order to form a comprehensive and accurate Lifestyle care plan".

63. RN C recalled that she cared for Mrs B at various times but not on every shift. She told HDC:

> "There were two RNs on morning shifts and there was an expectation that one would complete paperwork however commonly it was necessary for both RNs to undertake care of the residents."

64. RN C acknowledged that she was aware that Mrs B had been allocated to her as a primary resident, and that Mrs B's interRAI assessment had not been completed. RN C stated:

[16] RN C commenced full-time employment as a registered nurse in 2017, and reduced to part-time hours later in 2017.

> "I had more than one conversation with the then C[S]M requesting that [Mrs B] be removed from my list of primary residents as I simply did not have time to complete the [i]nterRai."

65. RN C commented that she completed her interRAI training on 26 Month2, and that the "interRAI is a complex assessment tool and takes a number of hours to complete". RN C told HDC: "Initially we were not allocated specific time within our nursing day to complete this. Later we were allocated separate days to do them."

66. RN C recalled nurses raising concerns about the lack of available time to complete all interRAI and other assessments "due to the volume of them as well as the heavy nursing workload". She stated that there was an expectation from management at WHL that "RNs would come in and complete assessments in their own time if necessary".

67. RN C commented:

> "I feel that I prioritised care to residents depending on acuity at the time in between the pressing paperwork. With a dramatic reduction in staffing over this time and new staff (leading to different staffing levels) I feel I completed these to the best of my ability."

68. RN C stated that she "left WHL due to concerns about the working environment".

69. RN D told HDC that on 8 Month4 when she completed written assessments and Lifestyle Care Planning for Mrs B, she had not been granted access to interRAI for WHL. RN D acknowledged that Mrs B did not have a completed interRAI assessment, despite several staff nurses being interRAI trained. RN D said that she sincerely regrets "that we fell short of our obligation to [Mrs B] in this area".

Last Days of Life Care Plan

70. The Last Days of Life Care Plan is a Ministry of Health endorsed tool that includes the essential components and considerations required to promote quality care and symptom control at the end of life. WHL has been using the Last Days of Life Care Plan and Toolkit since August 2017.

71. A short-term care plan was commenced on 12 Month4 for "Deterioration of Health Status", but a Last Days of Life Care Plan was not initiated for Mrs B. WHL told HDC:

> "Further deterioration in her condition should have triggered the use of The Last Days of Life Toolkit (including care plan) … During [Mrs B's] last days the RN's on duty did not fully comply with all Heritage Lifecare (HLL) procedures and processes related to End of Life care including the use of Last Days of Life documentation."

72. WHL stated: "We regret that the RNs did not follow HLL procedure."

73. Mrs B died on 21 Month4.

Further information

Investigation

74. WHL told HDC that the Facility Manager conducted an internal review and responded to a complaint from Ms A, but the documentation from the review could not be located.

75. WHL provided HDC with an undated investigation summary that included the following findings:

- Inconsistent documentation by registered nurses on the electronic medication management system[17] and in progress notes following administration of PRN pain relief.
- No non-pharmaceutical interventions initiated.
- No interRAI completed.
- No End of Life pathway initiated.

Responses to provisional opinion

76. Heritage Lifecare Limited (trading as Waiapu House Lifecare) was given an opportunity to respond to the provisional opinion and RN E's statement. Where relevant, Heritage Lifecare Limited's comments have been incorporated into the report above.

77. RN D was given an opportunity to respond to the relevant parts of the provisional opinion, and advised that she does not wish to comment further but expressed that now her practice is at a significantly higher standard.

78. RN E was given an opportunity to respond to the relevant parts of the provisional opinion. Where relevant, RN E's comments have been incorporated into the report above. RN E expressed regret to Mrs B's family and apologised that they felt that their family member was not respected by the staff at WHL. RN E stated: "[T]he nurses and myself were working over and above to ensure our residents felt their dignity was maintained and they were in safe hands." RN E told HDC: "[D]ue to being understaffed the result was, a resident's family felt their loved one did not receive appropriate care. For this I carry great sadness."

79. Ms A was given an opportunity to respond to the "Information gathered" section of the provisional opinion. She asked whether there are now more staff working with the number of patients at WHL. The improvements made by WHL are addressed in the "Actions taken" section of this report.

[17] Medimap.

Opinion: Heritage Lifecare Limited (Waiapu House Lifecare) — breach

Introduction

80. Heritage Lifecare Limited had a duty to provide services to Mrs B with reasonable care and skill. This included responsibility for the actions of its staff, and an organisational duty to facilitate the provision of reasonable care. Heritage Lifecare Limited also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, to ensure that "the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers".

81. Initially Mrs B was admitted to WHL on 18 Month2 for respite care, and, from 10 Month3 to her death on 21 Month4, she was a permanent resident requiring hospital-level care. I have a number of concerns about the care provided to Mrs B relating to the non-completion of the mandatory interRAI assessment, non-completion of the Last Days of Life Care Plan, and the Lifestyle Care Plan having been written belatedly for Mrs B's pain management, during a period of staff turnover and managerial change at WHL.

Lifestyle Care Planning

82. Mrs B's GP, Dr F, was very involved in her care at WHL. Dr F was kept informed of Mrs B's overall condition, including her levels of pain, and made various changes to the medication for Mrs B to manage her pain. Mrs B's pain during the last days of her life was monitored closely, and her medication prescription for pain relief was adjusted almost daily.

83. My in-house clinical advisor, RN Hilda Johnson-Bogaerts, considers that WHL's Pain Assessment and Management Policy and Procedure was comprehensive and included the use of non-pharmaceutical interventions and a holistic approach to pain relief. She advised that the Lifestyle Care Plan is an appropriate tool to plan such interventions that both engage and relax the consumer.

84. I note that the Lifestyle Care Plan was written for Mrs B belatedly on 8 Month4, and identified non-pharmaceutical interventions to assist with management of pain and/or agitation. RN Johnson-Bogaerts advised that there is little evidence of non-pharmaceutical therapies having been considered or implemented to manage Mrs B's pain. RN Johnson-Bogaerts stated: "[W]hile the care plan was developed (albeit with significant delay) nurses did not refer to it to inform personalised day to day nursing care."

85. RN Johnson-Bogaerts advised that "nurses must advocate for non-pharmacologic therapies, including psychological approaches, physical measures, integrative therapies, and interventional techniques, when appropriate" in addition to pain medication.

86. RN Johnson-Bogaerts further advised:

> "There is a risk that without timely quality care plans nursing care becomes reactive and the consumer feels disempowered. … In this situation I consider this a medium deviation from the practice standards."

87. I accept RN Johnson-Bogaerts' advice and am critical that the Lifestyle Care Plan was developed late, that non-pharmaceutical interventions were not utilised fully, and that there is little evidence that the Lifestyle Care Plan was used to inform Mrs B's daily nursing care once it had been written.

interRAI assessment

88. The interRAI Long Term Care Facilities Assessment Tool is the mandatory primary assessment tool for long-term residential aged care in New Zealand. During her stay at WHL, no interRAI assessment was initiated for Mrs B, despite this being a mandatory requirement under the Age-Related Residential Care Services Agreement between the DHB and Heritage Lifecare Limited (trading as Waiapu House Lifecare).

89. RN Johnson-Bogaerts advised: "Not using these clinical tools would be considered by my peers as poor clinical practice and is a **significant deviation from accepted practice**."

90. RN C was the nurse allocated to complete Mrs B's interRAI assessment, under the clinical leadership of the CSM. RN Johnson-Bogaerts stated:

> "[The failure to complete the interRAI assessment] would be seen by my peers as poor nurse leadership by the Clinical Manager who ultimately is responsible for outcomes and use of the systems … On the other hand the organisation's clinical governance/ quality assurance system should be able to pick up such gaps and include the monitoring of adherence to systems and procedures. An example of this could be that the Clinical Nurse Manager submits a Monthly Report to the organisation's Clinical Governance which includes the key performance indicator of something to the effect of 'Number of overdue interRAI assessments' and 'Number of overdue care plans'. A failure to monitor the care home's adherence to systems in terms of completion of interRAI assessments and care planning would be a clinical governance issue."

91. RN C told HDC:

> "There was high staff turnover at WHL during the time I worked there including RNs, managerial changes and a reduction in the number of Healthcare Assistants (HCAs). This meant a heavy workload for the RNs and resulted in many of the residents' lifestyle care plans and other assessments becoming overdue."

92. RN C stated that with two nurses on morning shifts there was an expectation that one would complete paperwork, but commonly both nurses were required to undertake care of the residents. RN Johnson-Bogaerts advised that it is good practice for the roster and staff hours to include sufficient time for direct care staff to complete their required clinical documentation and administration duties.

93. RN C told HDC: "It was conveyed by management at more than one meeting that there was an expectation that RNs would come in and complete assessments in their own time if necessary." RN C stated that she had notified the CSM in more than one conversation that

she did not have the time to complete the interRAI. RN E told HDC: "We tried but were unable at the time to recruit agency nurses to allow time off the floor."

94. WHL told HDC that it had an adequate number of interRAI-trained nurses, and RN Johnson-Bogaerts advised that the Allocation of Staff/Duty Rosters policy was in line with the Ministry of Health's national age-related residential care services agreement, and the rosters and timesheets used at WHL were in line with accepted practice. While I accept that minimum required staffing levels were complied with, it is apparent, as demonstrated by this case, that an increasing number of residents with complex comorbidities are receiving care in aged residential care facilities. This situation warrants ongoing careful attention to ensure firstly that the services standard and relevant aspects of the Age-Related Residential Care Services (ARRC) Agreement continue to meet residents' needs, and secondly that the sector is consistently interpreting the expectation relating to minimum required staffing levels. I would urge WHL to follow the terms of the ARRC Agreement and provide sufficient staff to meet the health and personal care needs of all residents at all times. When the registered nurse or CSM considers that additional staff are required to meet the needs of residents, WHL should ensure that extra staff are on duty.

95. I note that Mrs B was a resident at WHL during a period of high staff turnover, including a change in CSM. In this circumstance of change, WHL has an organisational responsibility to ensure continuity of care for residents, and I am critical that this did not occur for Mrs B.

96. I am critical that WHL did not have systems in place to ensure that Mrs B's interRAI assessment was completed within 21 days of her admission as a permanent resident. This was in breach of the Age-Related Residential Care Services Agreement, and meant that Mrs B's Lifestyle Care Plan was not informed by the detailed interRAI assessment. Without a completed interRAI assessment, there was a risk that Mrs B's care needs were not identified sufficiently, and interventions may not have been appropriate/adequate.

Last Days of Life Care

97. A Last Days of Life Care Plan was not initiated for Mrs B at WHL. On 12 Month4, a short-term care plan was commenced for Deterioration of Health Status. RN Johnson-Bogaerts advised:

> "The use of Short Term Care Plans for the provision of end of life care is an outdated way to plan nursing interventions at the end of life. The use of Te Ara Whakapiri [Last Days of Life Care] is the norm and has many advantages."

98. The Last Days of Life Care is a Ministry of Health endorsed tool that includes the essential components and considerations required to promote quality care and symptoms control at the end of life. WHL has been using the Last Days of Life Care Plan and Toolkit since August 2017.

99. WHL acknowledged to HDC:

> "Further deterioration in her condition should have triggered the use of The Last Days of Life Toolkit (including care plan) … During [Mrs B's] last days the RN's on duty did not

fully comply with all Heritage Lifecare (HLL) procedures and processes related to End of Life care including the use of Last Days of Life documentation."

100. The lack of a Last Days of Life Care Plan for Mrs B, combined with the absence of the interRAI assessment as discussed above, indicates that at the time of Mrs B's stay, WHL did not use these New Zealand mandated clinical tools systematically. RN Johnson-Bogaerts advised that this is a significant departure from accepted practice. I accept this advice and am highly critical that mandated tools were not used in Mrs B's care, and consider that this affected the quality of that care.

Conclusion

101. In my view, Heritage Lifecare Limited had the ultimate responsibility to ensure that Mrs B received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). WHL acknowledged that Mrs B's interRAI assessment and Last Days of Life Care Plan were not initiated, and that her Lifestyle Care Plan was written belatedly.

102. In my view, there were deficiencies in the care provided to Mrs B between Month2 and Month4, which were systemic issues for which Heritage Lifecare Limited bears responsibility. Mrs B was a resident at WHL during a period of staff turnover and managerial change, and ultimately it was Heritage Lifecare Limited's responsibility to ensure continuous care for Mrs B during this time of organisational instability. As outlined in detail above, the following issues occurred in the care provided to Mrs B:

- The Lifestyle Care Plan was written belatedly and not adopted into Mrs B's daily cares to manage pain.
- Mandatory interRAI assessment was not initiated.
- A Last Days of Life Care Plan was not initiated.

103. In light of these issues, I consider that the care provided to Mrs B by Heritage Lifecare Limited at WHL was inadequate, and resulted in appropriate assessment and interventions not being actioned for Mrs B to manage her pain and end-of-life cares. Accordingly, I find that Heritage Lifecare Limited did not provide services to Mrs B with reasonable care and skill, and breached Right 4(1) of the Code.[18]

104. I note that since these events WHL has taken a number of actions, including increasing the number of rostered hours for registered nurses, allocating specific time to nurses to complete interRAI assessments, and appointing a Clinical Quality Support nurse to monitor the completion of interRAI assessments and to provide support. I also note that WHL has now implemented the use of the Last Days of Life Care Plan tool.

[18] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Pressure injury management — no breach

105. I note that my in-house advisor, RN Johnson-Bogaerts, has reviewed the management of Mrs B's pressure injury and concluded that "proper professional standards were maintained". On admission to WHL, Mrs B had a stage 2 sacral pressure injury, which was reassessed as a stage 4 pressure injury on 5 Month3, and which became unstageable on 8 Month4.

106. RN Johnson-Bogaerts advised:

> "The consumer's clinical notes show entries that point in the direction of an 'unavoidable pressure injury'. Despite good efforts of pressure relief, nutritional supplementation and other measures, some pressure injuries are 'unavoidable'. This is the case when organ failure occurs including 'skin failure'.
>
> Unavoidable means that the individual developed the pressure injury and deterioration of the pressure injury occurred even though the provider had evaluated the individual's clinical condition and pressure injury risk factors; defined and implemented interventions that are consistent with individual needs, goals, and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate."

107. I accept the advice that the deterioration in Mrs B's pressure injury was unavoidable despite the appropriate care having been provided by WHL.

Pain management — no breach

108. Adequate pain and symptom management is an essential component of palliative and end-of-life care. Nurses must use evidence-based effective doses of medication prescribed for symptom control, and must advocate on behalf of patients when the prescribed medication is not managing pain and other distressing symptoms.

109. Faxes between the nurses at WHL and Mrs B's GP, Dr F, show evidence that the nurses were advocating on behalf of Mrs B by requesting pain medication reviews when they perceived that the prescribed pain relief needed to be reviewed. The clinical notes show that nurses were responsive to Mrs B's pain and performed regular assessments, followed by the administration of the prescribed medication when indicated.

110. RN Johnson-Bogaerts advised:

> "From a nursing point of view management of [Mrs B's] pain seemed to be in line with good practice. They provided pain relief as prescribed by the medical practitioners and communicated to the doctors when needed."

Opinion: RN E and RN D — adverse comment

111. The interRAI Long Term Care Facilities Assessment Tool is the mandatory primary assessment tool for long-term residential aged care in New Zealand. During her stay at WHL, no interRAI assessment was initiated for Mrs B, despite this being a mandatory requirement under the Age-Related Residential Care Services Agreement between the DHB and Heritage Lifecare Limited (trading as Waiapu House Lifecare). The assessment is required to be completed within 21 days of admission.

112. I note that RN Johnson-Bogaerts refers to the failure to complete the interRAI assessment as poor nurse leadership by the CSM. The CSM at WHL is responsible for providing high-level clinical leadership and support to clinical staff. RN E held the position up to 2 Month4, and RN D held the position from 5 Month4. I am critical that neither RN E nor RN D provided the support and guidance needed to ensure that Mrs B's interRAI assessment was completed.

113. I also note RN Johnson-Bogaerts' consideration of the system at WHL under which both CSMs were operating. She commented that "the organisation's clinical governance/quality assurance system should be able to pick up such gaps and include the monitoring of adherence to systems and procedures". She advised that "[a] failure to monitor the care home's adherence to systems in terms of completion of interRAI assessments and care planning would be a clinical governance issue".

114. I acknowledge RN Johnson-Bogaerts' advice that this is an example of poor clinical practice, and a significant deviation from accepted practice. I am mindful, however, that RN E resigned as CSM just over two weeks after Mrs B became a permanent resident, and that RN E left WHL before the interRAI assessment was due to be completed. RN E told HDC that when she left WHL, the date by which Mrs B's interRAI assessment should have been completed was not yet due, and the due date would have been evident for the next clinical manager to identify easily in the spreadsheets. It is evident that RN E expected that the interRAI assessment would be completed after she left. RN E also outlined the work pressures under which she was operating at the time.

115. I note that RN E did not provide a response to HDC until the later stages of the investigation. I am critical of her lack of engagement with this process, which caused delay in the investigation. I would strongly urge staff to obtain support from their professional bodies to ensure timely provision of information to investigations.

116. RN D was appointed as Acting CSM from 5 Month4, and told HDC that at this time she had not been granted access to interRAI for WHL. I am also mindful of the staffing issues raised by RN C, and that during Mrs B's admission to WHL there was a period of staff turnover and managerial change. I remain critical that WHL did not have the governance systems in place to manage this change and to ensure that Mrs B's mandatory interRAI assessment was completed.

Actions taken — Waiapu House

117. In response to issues raised about Mrs B's care, WHL told HDC that it has done the following:

- Increased registered nurse rostered hours, and nurses have been given specific time to complete interRAI assessments when needed.
- Appointed a "Clinical Quality Support RN — interRAI" to monitor the completion of assessments and to provide support. Resident assessment dates for interRAI, care plans, and GP/medication reviews are now collated and forwarded to the Quality Team every month.
- The Clinical Services Manager has instigated a management plan to ensure that interRAI assessments are completed within appropriate timescales.
- Monthly meetings are held for registered nurses, and meeting minutes are recorded. All resident issues are discussed, including upcoming due dates for assessments.
- Registered nurses, supported by the Facility Manager and Clinical Services Manager, take ownership of their actions and education.
- Last Days of Life Care (Te Ara Whakapiri) folders and documents have been made available in each nurses station.

118. Education sessions have been held for WHL staff, including:

- Palliative care education for nursing staff, including pain management, facilitated by the hospice, and further palliative care training for staff on two occasions.
- Falls prevention for staff.
- Documentation and a session on controlled drug training for nurses.
- Wound care for nurses.
- Leadership and EPOA for nurses.
- Pain and symptom management for nurses at the hospice.
- Palliative care and pain management for nurses.
- A skills booster interRAI course held for WHL.

Recommendations

119. I recommend that Heritage Lifecare Limited (Waiapu House Lifecare):

a) Provide a written apology to Mrs B's family for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Undertake regular Clinical Documentation Audits reviewing the quality of clinical documentation, including the quality of nursing care planning.
c) Undertake a quality improvement initiative[19] that ensures that assessments and care plans are living documents used to guide day-to-day nursing care in a consumer participatory way.
d) Noting the education sessions referred to in paragraph 118, schedule regular and ongoing education sessions for all WHL nursing staff on pain management and end-of-life care.
In response to the provisional opinion, Heritage told HDC that currently it is working on an end-of-life strategy plan, and this will be rolled out to all sites.
e) Use an anonymised version of this report as a case study, to encourage reflection and discussion during the above education sessions.
f) Include in the Allocation of Staff/Duty Rosters policy the responsibilities of the various "levels" of registered nurses.

Heritage Lifecare Limited is to provide evidence to HDC that points (b) to (f) above have been carried out, within six months of the date of this report.

Follow-up actions

120. A copy of this report with details identifying the parties removed, except Heritage Lifecare Limited, trading as Waiapu House Lifecare, and the expert who advised on this case, will be sent to the DHB, the Ministry of Health (HealthCERT and the Health of Older People Team), and the Health Quality & Safety Commission (HQSC), and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

121. I will also be writing to the Health of Older People Team at the Ministry of Health suggesting that it continue to monitor the profile of residents receiving care in aged residential care facilities across New Zealand and consider reviewing the guidelines for minimum required staffing levels as warranted.

[19] Using the HQSC toolkit for quality improvement initiatives:
http://www.hqsc.govt.nz/assets/Falls/PR/ARRC-QI-toolkit/ARRC-quality-improvement-toolkit-Apr-2016.pdf

Appendix A: In-house clinical advice to the Commissioner

The following in-house clinical advice was obtained from RN Hilda Johnson-Bogaerts:

"Thank you for providing this file for in-house aged care nursing advice in relation to the complaint from [Ms A] about the care provided by Waiapu House Lifecare to [Mrs B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. This advice is limited to the specific request to review management of [Mrs B's] pain; Management of [Mrs B's] pressure ulcer; any other matters that are a departure from accepted standards.

1. Documents reviewed

I reviewed the following information on file: Correspondence regarding the complaint namely copy of the complaint; Waiapu House Lifecare (WHL) response to the HDC complaint; clinical records including the Clinical Progress Notes, Nursing Assessments, Medication Administration Records, Pain Charts, Wound Assessment Forms and Care Plans, Wound photos, Family Communication Record, Nursing Care Plans; Doctors Treatment Notes, fax communication with GP, Daily Repositioning Charts.

2. Review of clinical records

[Mrs B] was admitted to the care home WHL, initially for respite care on 18 [Month2] and became a permanent resident on 10 [Month3]. [Mrs B] had '*a significant medical history with multiple terminal diagnoses*'. Her medical history includes chronic lymphocytic leukaemia, Parkinson's disease and recurrent pneumonia. Geriatrician's assessment documented on [the DHB's] letter to the consumer's GP state the following observation '*markedly cachectic*' on 14 [Month3].

[Mrs B] was admitted for palliative care and end of life care. At the time of her admission she had a sacral stage 2 pressure injury and she was prescribed Paracetamol and an opioid medication for pain relief on an 'as required' basis. Her sacral pressure injury deteriorated over time to the unstageable state as noted on 8 [Month4], she developed a stage 2 pressure injury on her heel before she died on 21 [Month4]. End of life care included pain management with the use of a syringe driver. Reviewing the documentation regarding pain management and the management of the pressure injury the following was found.

(i) Management of [Mrs B's] pressure injury

At the time of her admission [Mrs B] received a comprehensive nursing assessment followed by the development of a comprehensive care plan which included a specific care plan for the sacral stage 2 pressure injuries. A pain assessment was completed which identified the cause of her pain to be '*pressure on bottom*'. At this first day of her stay appropriate pressure injury prevention strategies were put in place. These included the use of an air-mattress, 2–4 hourly change of position, relieving the pressure to the pressure injury as well as preventing other pressure injury from developing on her

heels. The Progress Notes and the Repositioning and Skin Inspection Charts show that these interventions were maintained throughout the consumer's stay at the care home. Wound care plans were maintained.

On 5 [Month3] her wound was reassessed by the RN as a stage 4 injury. The reviewed documentation states that in addition to the pressure relief interventions already in place, the consumer was '*seen by a wound specialist*', and that she received '*supported food and fluid intake*'. Contributing factors to the deterioration were identified as '*immobility, lack of nutrition, compromised health, incontinence, fragile skin'.* The Progress Notes show that these measures were implemented; the Soft Tissue Care Plan entries show when the wound was redressed. Appropriate dressings were used and the wound was evaluated every time.

On 8 [Month4] the pressure injury was assessed as deteriorated to the unstageable stage. The wound management plan was updated and the notes show that the situation was discussed with the family. Photos were taken of the sacral pressure injury at different points in time showing the correct categorising of the severity by the nurses. Nursing care plans were updated on this date and show a comprehensive approach to the issue of pressure injury as well as pain management. Regular pain relief was initiated via a syringe driver on 7 [Month4]. Clinical notes show communication with the EPOA regarding the deterioration and management of the care going forward.

9 [Month4], the nurses noted a new pressure injury on the consumer's left heel despite the pressure injury prevention interventions.

Comments

The consumer's clinical notes show entries that point in the direction of an 'unavoidable pressure injury'. Despite good efforts of pressure relief, nutritional supplementation and other measures, some pressure injuries are 'unavoidable'. This is the case when organ failure occurs including 'skin failure'.

Unavoidable means that the individual developed the pressure injury and deterioration of the pressure injury occurred even though the provider had evaluated the individual's clinical condition and pressure injury risk factors; defined and implemented interventions that are consistent with individual needs, goals, and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

Reviewing the extensive documentation regarding the management of the consumer's pressure injury I conclude that proper professional standards were maintained.

(ii) **Management of [Mrs B's] pain.**

The consumer's medication administration records show the administration of Oxycodone as required almost on a daily basis from the time of her admission. The provider used an electronic medication management system; entries include the pain

rating by the consumer and the outcome of the administration of pain relief. Most days, pain was assessed as being severe often scoring 8 on a scale to 10.

The notes show that there were days [Mrs B] was distressed and Midazolam would be administered with variable results.

7 [Month3], a pain monitoring chart was commenced showing that nurses actively checked in with the consumer asking if she was in pain and documented the pain scores. The charts also document the interventions taken and its effect. All documented interventions are pharmaceutical.

Faxes to the GP were included in the clinical notes. These are written communications from the nurses to the GP requesting pain medication reviews. These faxes show that the nurses advocated on behalf of the consumer.

6 [Month4] regular pain relief by way of a syringe driver was prescribed. The Progress notes include nurses' communication with family explaining what this entails.

Comments

Adequate pain and symptom management is an essential component of palliative and end of life care. Total pain is the sum of four components: Physical, emotional discomfort, interpersonal conflicts, and non acceptance of one's situation. These four components may individually or in combination affect patients' perception of their total pain. Lack of understanding of the influence of each of these components may result in less-than-optimal pain management at the end of life. (Leleszi, March 2005)

Nurses must use evidence based effective doses of medication prescribed for symptom control, nurses must advocate on behalf of the patient when prescribed medication is not managing pain and other distressing symptoms. Additionally, nurses must advocate for non-pharmacologic therapies, including psychological approaches, physical measures, integrative therapies, and interventional techniques, when appropriate.

The clinical notes show nurses were receptive to the consumer's pain and performed regular assessments followed by the administration of the prescribed medication when indicated. They also advocated for the consumer when they perceived the prescribed pain relief needed to be reviewed. Despite this, I note that the consumer's pain scores indicate she was experiencing severe pain on a regular basis.

There is no evidence in the notes that the nurses considered or implemented non-pharmaceutical therapies.

(iii) Any other matters that amount to a departure from accepted standards

I note that no interRAI assessment was initiated by the RN which is a departure from accepted practice.

I note that no Last Days of Life Care Plan was developed and initiated which is a departure from accepted standard.

3. Clinical advice
In conclusion, it is my opinion that proper professional standards were maintained managing [Mrs B's] pressure injury.

From a nursing point of view management of [Mrs B's] pain seemed to be in line with good practice. They provided pain relief as prescribed by the medical practitioners and communicated to the doctors when needed, and advocated for [Mrs B].

I note that no interRAI assessments were completed by the nurses and that no Last Days of Life care plan was completed or initiated for [Mrs B's] end of life care.

InterRAI is the mandatory primary assessment tool for long term residential aged care in New Zealand. The Last Days of Life care plan is a Ministry of Health endorsed tool that includes the essential components and considerations required to promote quality care and symptom control at the end of life.

Not using these clinical tools would be considered by my peers as poor clinical practice and is a **significant deviation from accepted practice.**

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

Further clinical advice

The following further advice was received from RN Johnson-Bogaerts:

"1.Thank you for the request that I provide further clinical advice in relation to the care provided to [Mrs B] by Waiapu House Lifecare (WHL). My previous advice was on 23 November 2018. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. In particular I was asked to review the response and documentation provided by WHL in response to the notification of an investigation and advice whether the care provided by WHL was in accordance with accepted standards in relation to:

a. Non-pharmaceutical therapies and the timing of the Lifestyle Care Plan
b. InterRAI assessment — whether the failure to complete the assessments was a systems issue
c. Last Days of Life Care Plan — and the use of Short Term Care Plan for Deterioration of Health Status instead
d. The appropriateness of the staffing levels across 24 hours
e. Appropriateness of the identified changes

3. Documents reviewed

- Response from WHL and further attachments to the response
- Response to s62 request for info
- Staff rosters

4. Review of provided records and clinical advice

a. Non-pharmaceutical therapies and the timing of the Lifestyle Care Plan

The WHL investigation report that was part of the response confirmed '*The Lifestyle Care Plan (written on 8 [Month4]) identified non-pharmaceutical interventions to assist with management of pain/agitation however, there is only one entry stating music was playing in [Mrs B's] room. There is no evidence that any other non-pharmaceutical therapies were considered or implemented to manage [Mrs B's] pain.'* The information provided shows that [Mrs B's] pain during the last days of her life was monitored closely and her medication prescription for pain relief adjusted almost daily. The provider's Pain Assessment and Management Policy and Procedure is comprehensive and based on good practice including the use of non-pharmaceutical interventions and a holistic approach of pain symptoms. The Lifestyle Care Plan is an appropriate tool to plan such interventions that both engage and relax the consumer. It would appear that while the care plan was developed (albeit with significant delay) nurses did not refer to it to inform personalised day to day nursing care.

In conclusion, nursing care planning was delayed and it would appear that the Lifestyle Care Plan was not used to inform day to day personalised nursing care. There is a risk that without timely quality care plans nursing care becomes reactive and the consumer feels disempowered.

https://www.healthnavigator.org.nz/clinicians/c/care-planning/

In this situation I consider this a medium deviation from the practice standards.

b. InterRAI assessment — whether the failure to complete the assessments was a systems issue

WHL provided a copy of their spreadsheet as their system to keep track of interRAI assessments and their due dates. This is an acceptable system and commonly used in the aged care sector. The provider reported to have an adequate number of interRAI trained nurses. Despite this the interRAI assessment was not completed. This would be seen by my peers as poor nurse leadership by the Clinical Manager who ultimately is responsible for outcomes and use of the systems.

On the other hand the organisation's clinical governance/quality assurance system should be able to pick up such gaps and include the monitoring of adherence to systems and procedures. An example of this could be that the Clinical Nurse Manager submits a Monthly Report to the organisation's Clinical Governance which includes the key performance indicator of something to the effect of 'Number of overdue interRAI

assessments' and 'Number of overdue care plans'. A failure to monitor the care home's adherence to systems in terms of completion of interRAI assessments and care planning would be a clinical governance issue.

http://www.hqsc.govt.nz/assets/Capability-Leadership/PR/HQS-ClinicalGovernance.pdf

c. Last Days of Life Care Plan — and the use of Short Term Care Plan for Deterioration of Health Status instead

The use of Short Term Care Plans for the provision of end of life care is an outdated way to plan nursing interventions at the end of life. The use of Te Ara Whakapiri is the norm and has many advantages https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life. [RN D] explained in her letter dated 30 July 2019 that the registered nurse who developed the care plan included the '*LCP*' which I presume refers to the Liverpool Care Pathway principles which predated the present framework to plan end of life care. This gives confidence as to the quality of the care planning. In that case I consider this as a minimal deviation from accepted standard.

d. The appropriateness of the staffing levels across 24 hours

Staffing rosters were provided which comply with the minimum required staffing levels on duty as set by the Age Related Residential Care Service Agreement. There is however no set quantitative standard that sets out what appropriate staffing levels should be. The ARC agreement requires the provider to follow the recommendation of the registered nurse and to ensure that the staffing levels as advised by this registered nurse are present. The advising registered nurse needs to set the staffing levels such that the needs of all residents can be met. Therefore, adequacy of staffing levels is hard to judge on the basis of resident numbers only and without knowing the acuity and care needs of each resident at that time. Perhaps a statement of the senior nurse on duty at those specific times would be a way to gauge appropriateness of staffing levels. For planning purposes, providers and nurses can monitor the adequacy of staffing levels by way of monitoring adverse outcomes and quality indicators such as the number of falls, skin tears, UTI, etc. Does WHL have a policy/procedure relating to monitoring of safe staffing levels and was this adhered to?

e. Appropriateness of the identified changes

I note the following appropriate changes mentioned in the letter of response from [the] Quality Assurance Lead, dated 22 August 2019:

- Increase in RN rostered hours and RN being given specific time to complete interRAI assessments when needed.
- The appointment of a Clinical Quality Support RN — interRAI to monitor monthly the completion of assessment and provide support where needed.

It is my recommendation that if not already in place the following changes are introduced in addition:

- A regular Clinical Documentation Audit reviewing the quality of clinical documentation including quality of nursing care planning
- A quality improvement initiative which ensures that the assessments and care plans are living documents used to guide day to day nursing care in a consumer participatory way.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

Further clinical advice

The following further advice was received from RN Johnson-Bogaerts:

"Thank you for the request that I provide further clinical advice on the care provided by Waiapu House Lifecare (WHL) to [Mrs B]. My previous advice was dated 23 November 2018 and 14 November 2019. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

I was asked to review the additional information provided by WHL and RN C ([Mrs B's] primary nurse) and consider whether the information changes any of the previous advice. In particular, I was asked to comment on and define any degree of departure for the following:

i. The adequacy of the Allocation of Staff/Duty Rosters policy and rosters and timesheets used at WHL.
ii. The non-completion of the interRAI assessment. Consider the appropriateness of staffing levels at WHL and how this impacted on [Mrs B's] care and completion of the interRAI assessment, as referred to in [RN C's] statement (see C1 below).
iii. The appropriateness of the changes made by WHL to manage interRAI assessments since these events.

I was also asked to elaborate on my previous advice that 'Not using these clinical tools would be considered by my peers as poor clinical practice and is a significant deviation from accepted practice' relating to my comments:

- 'I note that no interRAI assessment was initiated by the RN which is a departure from accepted practice.'
- 'I note that no Last Days of Life Care Plan was developed and initiated which is a departure from accepted standard.'

And clarify if they are each a significant departure or when combined.

Documents reviewed

- WHL response dated 2 December 2019 and 4 appendices
  - Appendix 1 — Te Ara Whakapiri
  - Appendix 2 — Policies
  - Appendix 3 — Waiapu — interRAI and Care Plan data October 2019
- [RN C's] response dated 25 February 2020

Clinical advice

i. The adequacy of the Allocation of Staff/Duty Rosters policy and rosters and timesheets used at WHL.

Reviewing the Allocation of Staff/Duty Rosters policy and the Rosters and Timesheets document used at WHL I note the following. The document states in relation to staffing levels that '*A base roster showing staff designation and hours will be set according to the needs of the client groups, individuals and numbers'* and *'There will be sufficient staff at all times to meet the assessed needs of the residents'* and further in the document '*when specific needs indicate, an increase in staff levels may be required …'* This intention is in line with the Residential Aged Care agreement.

The document however does not state who is accountable and responsible for setting the 'base roster' levels nor the day to day adjustments of the base roster to the changing residents' mix and individual acute needs.

The document does not include a process for monitoring the adequacy of staffing levels nor a process for the senior registered nurse on duty to escalate a request for additional direct care staff if and when needed.

In addition to the statement that there will be sufficient staff at all times to meet the assessed needs of the residents it is good practice for the roster and staff hours to also include sufficient time for direct care staff to complete their required clinical documentation and administration duties.

I am concerned that this document does not provide sufficient support and guidance to senior registered nurses to be able to exercise their obligation to ensure safe staffing levels on each shift.

In conclusion I don't consider the provided policies to be adequate as staffing levels policy/procedure. **Deviation from accepted practice: moderate.**

ii. The non-completion of the interRAI assessment. Please consider the appropriateness of staffing levels at WHL and how this impacted on [Mrs B's] care and completion of the interRAI assessment, as referred to in [RN C's] statement (see C1 below).

[RN C's] statement includes that at the time there was high staff turnover, managerial changes and a reduction in the number of Healthcare Assistants resulting in a heavy

workload for the RNs and resulting in many of the residents' 'care plans and other assessments becoming overdue'.

She states that while there were two RNs on morning shifts and there was an expectation that one would complete paperwork, commonly it was needed for both nurses to undertake care of the residents.

Further she states that '*It was conveyed by management at more than one meeting that there was an expectation that RNs would come in and complete assessments in their own time if necessary*'. And that she had notified the Clinical Nurse Manager (CNM) in more than one conversation that she did not have the time to complete the interRAI. To date we did not receive a response from the then CNM to moderate this statement.

Following [RN C]'s statement it is good to hear that the RNs prioritised the care of the residents over the administrative tasks while staffing levels were insufficient to complete both essential nursing duties. This would have reduced the potential immediate negative impact on care. Further to the review I completed in November I concluded from reading the provided clinical documentation that overall proper professional standards were maintained managing [Mrs B's] pressure injuries and pain management.

[RN C's] statement includes that an interRAI assessor was appointed later to assist nurses with the work. This indicates that action was taken in response to the identified shortage of time to complete these.

The question remains if action was taken by the CNM who was aware of the staff levels being below normal at the time and causing nurses to fall behind on their essential administrative duties. In the situation as described by [RN C], that no attempt was made to find replacement or temporary staff bringing the staffing levels to normal on each duty, I would consider this in this situation as a **significant departure from accepted practice because of its potential to negatively impact quality of care.**

iii. The appropriateness of the changes made by WHL to manage interRAI assessments since these events.

The provider's response includes that since September 2018 they now have an interRAI Clinical Support RN who monitors weekly adherence to systems and procedures including interRAI assessments due by facility, organises skills booster courses, does monthly reporting on overdue assessments and care plans.

In addition to this action I recommend as previously stated under point (i.) above that RNs are systematically provided sufficient time as part of rostered staff time to complete the interRAI assessments and care planning they are responsible for.

Additional request to elaborate on my previous advice that 'Not using these clinical tools would be considered by my peers as poor clinical practice and is a significant deviation from accepted practice'. This comment related to the finding that no interRAI

assessment preceded [Mrs B's] Care Plans and that no Last Days of Life Care Plan was developed and initiated to guide [Mrs B's] end of life care. This indicates that at the time the care home did not systematically use these New Zealand mandated clinical tools which combined would be seen as a significant departure from accepted practice.

The provider included an anonymised Last Days of Life Care Plan showing that they now have implemented the use of this tool.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner

30 October 2020 — Addendum to advice after receipt of provider response (29 October 2020)

I was asked to review the provider's response and consider whether this changes any of my previous advice.

In this response the provider explained the process by which Heritage's usual operations and expectations of certain positions are involved in setting the base roster. This sits with the care home manager with input from registered nurses. Further it was explained that there is a roster monitoring tool which is the process that monitors the adequacy of staffing levels. In terms of escalation at times when the need is high it was explained that the clinical services manager or care home manager is always on-call for any issues including a need for extra staffing.

Based on this new information I am changing my previous advice regarding the adequacy of the Allocation of Staff/Duty Rosters policy and rosters and timesheets used at WHL **to be in line with accepted practice**. I would like to make the recommendation that the provider includes in the policy the responsibilities of the various 'levels' of registered nurses."

Appendix B: Relevant standards

The Age-Related Residential Care Services Agreement

Section D15A on the use of interRAI states: "You[1] must implement and use interRAI as the primary means of assessing Residents in accordance with the requirements of this Agreement."

Section D16.2 b on assessment on admission states: "[E]ach Resident has an interRAI LTCF assessment completed within 21 days of admission to your Facility, in order to inform the Resident's Care Plan."

The New Zealand Health and Disability Services (Core) Standards, NZS8134:2008, state:

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

[1] The provider of age-related residential care.