Oceania Care Company Limited

Registered Nurse, RN E

A Report by the

Aged Care Commissioner

(Case 20HDC02116)

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Executive summary

1. This report concerns the care provided to a man when he was admitted to Victoria Place Rest Home and Hospital for respite care in 2019.

Findings

2. The Aged Care Commissioner found that Oceania Care Company Limited failed to provide services to the man in accordance with Right 4(4), Right 4(1) and Right 4(2) of the Code. The Aged Care Commissioner considered that Oceania Care Company Limited failed to follow the falls management policy that was in place, assessments were not undertaken as expected, and documentation was incomplete. The Aged Care Commissioner was also critical that Oceania Care Company Limited had failed to implement a positive culture at Victoria Place Rest Home and Hospital with residents' wellbeing at the forefront.

3. The Aged Care Commissioner also found that a registered nurse failed to provide services to the man with reasonable care and skill and breached Right 4(1) of the Code. The Aged Care Commissioner considered that the nurse failed to ensure that documentation was completed or that the man received adequate follow-up or monitoring by staff. The Aged Care Commissioner was also critical that staff did not undertake adequate assessments of the man following an unwitnessed fall or follow the Falls policy, and staff did not respond to the man's deteriorating condition adequately. The Aged Care Commissioner also expressed concern about staff members' rude and dismissive manner towards the man and his family.

Recommendations

4. The Aged Care Commissioner recommended that Oceania Care Company Limited and the staff involved provide written apologies to the man's family. The Aged Care Commissioner also recommended that Oceania Care Company Limited provide training to staff about current documentation policies, and the importance of having a comprehensive and up-to-date record of a resident's care and needs; arrange an independent audit of patient records at Victoria Place Rest Home and Hospital to assess compliance with documentation policies and professional standards; use this report as a basis for staff training at Victoria Place Rest Home and Hospital focusing particularly on the breaches of the Code identified; and review the admission policy and ensure that it includes clear guidance on the requirements for a resident being admitted for respite care. The admission policy is to include an acknowledgment and awareness that residents accessing respite care are among the most vulnerable and high-risk cohort; a full clinical assessment for each admission in order to understand any new clinical issues that have arisen since the previous respite admission, and subsequently develop an appropriate care plan; clear guidance on how to access timely nurse practitioner/GP support when required, and the responsible clinician for this group of residents; and documented process to guide pre-admission, such as a checklist for managers and nursing staff to ensure that all required information is collected in a consistent manner.

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5. The Aged Care Commissioner also recommended that the staff involved in the man's care each undertake training on falls management, communication with consumers, and record-keeping.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her late father, Mr B, by Oceania Care Company Limited. The following issues were identified for investigation:

- *Whether Oceania Care Company Limited provided Mr B with an appropriate standard of care from Day 1*[1] *to Day 3 2019 (inclusive).*
- *Whether RN E provided Mr B with an appropriate standard of care from Day 1 to Day 3 2019 (inclusive).*

7. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

8. The parties directly involved in the investigation were:

Mrs A	Complainant
Mrs B	Consumer's wife
Oceania Care Company Limited	Provider
RN C	Provider/registered nurse
RN D	Provider/registered nurse
RN E	Provider/registered nurse

9. Further information was received from Te Whatu Ora and an ambulance service.

10. Independent clinical advice was obtained from a registered nurse, Associate Professor Karole Hogarth (Appendix A).

Information gathered during investigation

Introduction

11. Mr B, aged in his eighties, had several medical conditions, including Parkinson's disease, severe aortic stenosis (narrowing of the aortic valve opening), heart failure, blindness in one

[1] Relevant days are referred to as Days 1–3 to protect privacy.

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eye, shortness of breath, poor hearing, and recurring TIAs (transient ischaemic attacks — mini strokes).

12. In 2018, general practitioner Dr F provided Mr B with a letter covering the care the cardiologist had recommended should Mr B need medical attention. The letter includes: '[S]hould such near-stroke symptoms recur, he would need to call an ambulance to be assessed in ED for transfer to [Hospital 2] for consideration of CT scan and possible thrombolysis.[2]'

13. Mr B's daughter, Mrs A, told HDC that despite his infirmities, her father was still a very 'with it', intelligent, stoic and gentle man. He had been living at home with his wife, Mrs B, and on the morning of Day 1 Mr B's carer showered him, dressed him, and drove him to Victoria Place Rest Home and Hospital (VPRH), where he was to have respite care. Mrs B said that at that stage there was no bruising on him.

Victoria Place Rest Home and Hospital

14. VPRH is owned and operated by Oceania Care Company Limited (Oceania). It offers dementia care, hospital-level care, palliative care, and respite care and is located close to Hospital 1.

15. RN E told HDC that the key responsibilities of her role included leadership and management, quality systems and audit, taking ownership of the business, human resources, and health and safety. She said that she was required to identify and resolve deficiencies in staff skills and competence, but at that time she was not aware of any such deficiencies.

16. In response to the provisional opinion, RN E said that her role was to offer clinical support and not to supervise staff.

Admission for respite care Day 1

17. Mr B was admitted to VPRH for five days of respite care.

18. In response to the provisional opinion, Mrs A told HDC that both her parents were hearing impaired. Mr B could not wear hearing aids, and her mother was unable to wear her hearing aids very often or for long. Both also suffered from severely diminished vision. Mrs A said that her mother consulted with the rest of the family about respite care, and her mother reluctantly made the decision for Mr B to receive respite care for her own wellbeing. VPRH was close to their residence, meaning that Mrs B would not have to drive far to visit her husband, and her daughter was also able to visit him. Mrs A said that once Mr B had been admitted, her mother felt able to go home to try to catch up on rest and sleep, because Mr B had stayed at VPRH previously.

19. Mrs B stated that she was with her husband when he was shown into a room with an en suite bathroom. She said that a trainee, assisted by a registered nurse, attended to him and filled in most of the admission form.

[2] Medications or a minimally invasive procedure to break up blood clots and prevent new clots from forming.

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20. Oceania told HDC that prior to Mr B's admission, VPRH staff had told the family to bring in a current medical problems list, a current prescriptions list, and medications to cover the respite period. Oceania said that the admission agreement outlined the provision of 'hotel services' and personal cares, and its contractual obligations with the then district health board (DHB) for the provision of respite care.

21. In response to the provisional opinion, Mrs A said that it was assumed that staff must have known about Mr B's health issues, as he had Parkinson's disease and was unsteady on his feet and was also partially blind and hard of hearing. He was unable to be left on his own and needed assistance with mobilising, showering, toileting, and dressing. Regardless of this, Mrs B reminded and updated the staff on everything, including giving them a copy of the cardiologist's instructions to Dr F to contact an ambulance and take Mr B straight to Hospital 2 for any suspected heart trouble or suspected strokes.

22. On admission, Mr B had initial baseline observations taken. His dietary requirements were noted, other initial assessments were undertaken, including continence and pain, and an interim care plan was completed. Mr B signed a general consent and an advance directive stating that he wanted resuscitation and active hospital cares if he became unwell. The initial care plan indicated that Mr B had a good appetite. His pain assessment indicated that it was usual for him to have a general overall body ache.

23. The initial care plan indicated that Mr B was independent with walking using a walking aid. However, no falls risk assessment was undertaken, and he was not deemed to be a falls risk, despite using a walker for mobilising. Oceania accepted that Mr B's initial falls assessment was not adequate. Oceania noted that Mr B had been receiving respite care with VPRH since 2015, so staff were generally familiar with his mobility and falls risk.

24. Oceania stated that Mr B's initial care plan commented on his use of an aid with his mobility, and the clinical documentation suggests that a sensor mat was in place and that Mr B was orientated to the call bell in his room. Regarding the use of the sensor mat, Oceania said that when Mr B had visitors or if he was sitting on the edge of his bed during mealtimes, the sensor mat would be tucked under the bed to prevent accidental triggers of the alarm.

25. Oceania told HDC that on the evening of Day 1, Mr B settled in bed at around 6pm.

Day 2

26. The overnight healthcare assistant recorded that Mr B slept well, two-hourly checks were completed, and no concerns were voiced. The records state that in the morning Mr B was washed and changed and had only a 'fair' intake of food and fluids. At 11am he was given Panadol (20ml) for back pain, and the records state that he slept for most of the shift. Oceania said that there does not appear to have been any further assessment regarding his back pain.

27. Mrs B said that when she visited Mr B that morning, she met him coming from his bathroom. He was using his walker and said in a shaky voice, 'I have had the most terrible night of my

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life!' She said he told her that during the night he had needed to use the bathroom, but he could not see in the dark and could not find the call bell. He said that eventually he got out of bed as he was desperate to use the toilet, and he groped around in the dark and fell. He did not know how long he lay on the floor, but eventually he pulled himself up onto the bed and found that he had wet himself.

28. Mrs B said that at about 3.30pm, she informed RN D that Mr B had told her that he had fallen during the night, and RN D said that '[i]t was unwitnessed'. Mrs B stated that she pointed out that he had bruising on his elbows and forehead, and carpet graze marks on his feet, and the nurse replied: 'We don't know that he has fallen. He could have just bumped into a doorway.'

29. In response to the provisional opinion, RN D told HDC that she cannot recall any conversation to this effect and said that she would not have spoken this way to Mrs B. However, RN D apologised if she had spoken this way.

30. RN D assessed Mr B's observations, which were normal, although his oxygen level at 94% was lower than his baseline of 99% on admission. She recorded at 3.30pm: 'On assessment, he walks well to the toilet with walking frame, [observations] taken. ROM (range of movement) on upper arms are equal in strength.'

31. RN E said that RN D asked her to assist her to assess Mr B.[3] RN E stated that she went with RN D to Mr B's room, assessed him, and advised RN D to undertake further monitoring. RN E said that she asked Mr B whether he had experienced any headaches or any other pain, or any blurred vision or distress. She recorded: '[A]ble to present full ROM, denied any headaches and nil other pain. No blurred vision reported. Able to communicate freely without any distress.'

32. The VPRH staff did not complete an incident/accident report form, notify the general practitioner, conduct a Post Falls Assessment to identify contributing factors for the fall, or perform 24 hours of post-fall neurological observations as required by the Falls Management Policy (see below). RN E told HDC that each registered nurse is responsible for their own practice and following up on or reporting incidents. She said that she did not review those forms as she had no reason to believe that RN D would not have completed the necessary reports, notifications, and monitoring. RN E stated: 'She was an experienced RN, and I had no concerns about her performance at that time.'

33. RN D told HDC that she did not complete an incident form at the time as there was no evidence that Mr B had fallen as he had been checked regularly.

34. Mrs B said that Mr B lay down on the bed. He told her that his back was very sore, and he did not eat much as he was feeling so unwell. Mrs B said that she asked for him to be

[3] RN E and RN D are no longer employed at VPRH.

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transferred to hospital, but RN E's view was that his observations did not demonstrate a need for this, and she decided to keep him at VPRH.

35. RN D told HDC that she and RN E both decided that based on the assessments, a transfer to hospital was not required. This was discussed with Mrs B, and they felt that she understood.

36. Oceania said that Mrs B told the staff that she thought her husband had had a TIA. Oceania denied that Mrs B asked for a hospital transfer and said that she requested that they contact the GP for advice, but this was not done.

37. Mrs B said that RN E told her that she would put a light-up mat by Mr B's bed that night, but that did not occur, and when Mrs B asked the staff about it the next day, they said they had forgotten to do it.

38. At 4pm RN C took another set of observations, as Mrs B was concerned about Mr B's breathlessness. His oxygen saturation was now 93% and his respiration rate (RR) was 28 breaths per minute, which was significantly higher than on admission. The healthcare assistant recorded that Mr B was short of breath and had a raspy voice. RN C advised Mr B to sit upright in bed, which had some effect. There is no record of any follow-up after this assessment. RN C told HDC that after advising Mr B to rest with his head elevated, his breathing improved and his range of motion in his arms and legs was good. He denied having pain. She stated: 'At this point he was settled in bed. I did not feel that any further assessment was required.'

Day 3

39. Mrs B said that when she visited Mr B in the morning on Day 3 he was curled up in bed in a fetal position, using the wall as a support, resting his head awkwardly, and he was still in his pyjamas. She said that he was slurring his words slightly, which usually meant that he had suffered a TIA. He told her that he had a terrible pain in his lower back, and it felt as if some vital organ had been injured.

40. Oceania said that Mr B was unwell before lunch and went to bed after lunch with a pain in his right-hand side. There is no record on the medication chart of further analgesia being given, and Mr B's observations are not recorded in the progress notes or on the observation chart.

41. Mrs B said she showed the nursing staff the letter written by Dr F on 11 April 2018 outlining specific procedures that had been requested by the cardiologist at Hospital 2 should Mr B require medical attention. She stated that she also showed it to a staff member in the office, who said, 'Oh, that's old,' and brushed it off. RN E told HDC that she cannot recall being shown the letter and added: 'I can safely say that, if the letter was shown to me, a photocopy of the letter would have been recorded in the file.' RN C made no comment to HDC about whether she was shown the letter.

42. Mrs B stated that she called for help as Mr B needed to go to the toilet. A carer came and Mr B struggled to the bathroom using his walker. The carer placed him on the toilet and said,

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'I'll be back in a minute,' then walked out of the bathroom and down the corridor. Mrs B stated:

> 'She left [him] sitting there with no bell, left him sitting there with the doors open — no privacy. I was sitting in a chair thinking that she would be back soon. [He] called out, "Help me, I can't pee" then he repeated that his back hurt him.'

43. Mrs B said that eventually the carer came in and assisted Mr B off the toilet and back to bed, where he lay down again, 'all curled up in pain'. Mrs B stated that she went to talk to the staff, and RN E, RN C, another woman, and the reception staff were present. Mrs B told RN E and RN C that Mr B needed help, and RN C replied: 'Oh, I'll give him an anti-depressant to calm him down.' RN E told HDC that she cannot recall RN C making that statement, and RN C denied having said this.

44. Mrs B stated that she asked for a doctor to come for Mr B, and the nurse told her that this would not happen as doctors did not come to VPRH. RN C also denied having made this statement.

45. RN E said that she did not hear this statement made to Mrs B. RN E stated that VPRH has contracted doctors who visit on designated days to provide services to long-term care residents only. Mr B was a respite client so he would not be under the care of the doctors who visit VPRH, and he was still under his own GP while at the facility.

46. Mrs B said that she returned to the room and spoke to Mr B, who said that he was feeling sick and wanted to go home. She went back to her house and telephoned her daughter-in-law, who immediately drove there.

47. Mrs B and her daughter-in-law went to VPRH, and her daughter-in-law asked for an ambulance to be called. Mrs B said that there was a lot of discussion amongst the staff about this, and they asked whether there really was a need to do so. Mrs B said that her daughter-in-law told staff that if no ambulance was called, she would take Mr B in a wheelchair to the hospital herself, and Mrs B mentioned Mr B's back pain again. Mrs B stated: 'The RN asked [Mr B] to sit up, then roughly pulled up his top, poked at his back and said that there was no bruising.'

48. RN C said that Mr B did not report any back pain to her, and she did not tell Mrs B that Mr B had no bruising on his back. RN C said that she did not observe any bruising on Mr B's arms, legs, or head.

49. Mrs B said that Mr B was struggling to breathe and, eventually, after a lot of confusion and delay, an ambulance was called.

50. RN E said that she did not conduct a further assessment of Mr B on Day 3 because the registered nurses were responsible for following up on cares, and she had no concerns about the performance of the registered nurses at that time.

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51. There are no further entries in the progress notes until 3.35pm on Day 3, when there is a record that an ambulance had been called. RN E said that she did not review the records because it was the responsibility of each registered nurse to maintain records.

52. Oceania told HDC that the handover sheets from the morning shift to the afternoon shift indicate that a further set of observations was taken, and Mr B's blood pressure (BP) was lower than his previous BP, his oxygen saturations were also lower than those previously taken, and his respiratory rate had settled.

53. RN E said that a set of observations was taken by RN G. RN E stated that she assisted RN G, who had escalated to her that Mr B was short of breath and asked her to call the ambulance.

54. RN E recorded that three calls were made for an ambulance — at 2.27pm, 2.47pm, and 3.05pm — and at 3.15pm the ambulance service called VPRH asking for Mr B's vital signs and symptoms. RN E said that she relayed the observations taken by RN G. The progress notes state that a set of observations was given to the ambulance crew, but the actual observations are not noted in the progress notes. The reason for calling the ambulance is not recorded.

55. RN E said that she documented the ambulance delays as they were happening, but her final documentation was completed retrospectively after the ambulance had arrived. However, the documentation is not stated as being retrospective. RN E told HDC:

> 'I do not know why I did not write the reason the ambulance was called in the progress notes, but this information was handed over verbally when I telephoned the ambulance service.'

56. Mrs B stated:

> 'I consider that the RN and other staff member (I can't recall her name but know what she looks like) acted in a callous manner in dealing with [Mr B], myself and my daughter in law. Their attitude was aggressive, defensive and abusive. As we were leaving [VPRH], the RN said, "See, you were right after all". Small comfort.'

Ambulance service

57. Mrs B said that when the ambulance arrived, the crew immediately attended to Mr B and asked the registered nurse whether there was oxygen on site. Mrs B said that the nurse hesitated and said, '[N]ot really, not for this, if you know what I mean?', so the ambulance team brought in oxygen and administered it to Mr B. RN E said that VPRH keeps a stock of oxygen cylinders in the treatment room, and she does not recall the ambulance officers asking to use the facility's oxygen.

58. The ambulance service records state that Mr B was alert and orientated, although working quite hard to breathe. He was sweaty, pale, and hypertensive, with an irregular pulse. He reported pain in his lower back from a fall two nights previously, and he said that the pain

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was 9/10 on the pain scale when he was moved. The ambulance service record notes that Mr B had bruising on his arms, legs, and head. He was transported to Hospital 1.

Hospital 1

59. Mr B was admitted to Hospital 1 on Day 3. He was noted to be improving clinically while on the ward.

60. On Day 4 Mr B woke up with a left-sided headache, and nursing staff were concerned about his right-sided facial droop. He was reviewed by a doctor and noted to have a mild right-sided facial droop and decreased power in his right upper and lower limbs. His speech was slurred compared to the previous day, and it was queried whether he had suffered a haemorrhagic stroke.[4] After discussion with the general medical registrar at Hospital 2, Mr B was transferred there for a CT brain scan.

Hospital 2

61. Mr B's brain scan showed new left basal ganglia lacunar infarcts (strokes) when compared to a scan performed five months earlier. He was started on dual anti-platelet treatment and his dabigatran (blood thinner) was stopped.

62. Mr B continued to decline, and his respiratory rate increased. A chest X-ray showed left lower lobe consolidation (pneumonia) and he was started on IV (intravenous) antibiotics. Despite this, he continued to worsen and, after discussion with his family, the decision was made to focus on keeping him comfortable.

63. Sadly, Mr B died two weeks later.

DHB review

64. Following a request from Mr B's family, the then DHB conducted a clinical review of his care. The review found that the immediate clinical response to the report of Mr B's unwitnessed fall was appropriate, but VPRH did not meet its own standard of practice for follow-up after the fall.

65. Regarding Mr B's breathlessness and deterioration, the review found that VPRH's immediate clinical response to the report of his breathlessness was appropriate, but there was no follow-up of his condition after the immediate nursing intervention, to assess the effectiveness of the intervention and/or detect any further deterioration or improvement. That did not meet the expected standard of practice. There is no record of any further assessment or intervention after that point, which meant that the documentation did not meet professional standards or VPRH's own standard, and there is no evidence of an appropriate response to Mr B's deterioration from 4pm on Day 2 until 2.27pm on Day 3, when an ambulance was called.

[4] A stroke due to bleeding into the brain by the rupture of a blood vessel.

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66. The review found that there was no documentation of any ongoing clinical assessment, which suggested that VPRH had no clinical evidence on which to a base a decision about Mr B's need for transfer to hospital.

Record-keeping

67. Oceania told HDC that there is a lack of information in Mr B's clinical records. It accepted that this did not meet its own standards of clinical practice and generally accepted standards of care. It noted that no incident report was completed by clinical staff on being alerted to Mr B's fall and said that a report should have been completed as required by Oceania policy.

68. In response to the provisional opinion, Oceania told HDC that the policy on documenting in the progress notes is that healthcare assistants document in the progress notes at every shift. The registered nurse must document in the progress notes for hospital-level residents in the morning and afternoon shifts and in the night shift if there are acute changes to the resident.

Oxygen therapy

69. Oceania has an Oxygen Therapy Policy that advises on oxygen therapy for emergency use. Residents who require long-term oxygen therapy have this prescribed individually. Oceania said that each of its facilities has portable oxygen cylinders ready for use in an emergency. In response to the provisional opinion, Oceania said that it was not accepted practice to fail to provide oxygen when requested by the ambulance staff. Outside of an emergency, the resident's GP or nurse practitioner would be contacted to assess the resident prior to oxygen use.

70. Oceania stated that in Mr B's case, there is no evidence that the GP was contacted when Mr B's oxygen saturations dropped or following the observation that he was short of breath. Oceania accepted that a GP review should have been requested. Oceania also accepted that its Oxygen Therapy Policy was not followed and stated: 'There was a deficiency in clinical observation of Mr B with no evidence of a short-term care plan for his shortness of breath.'

Falls Management Policy

71. The Falls Management Policy 2012 states:

> 'Assessment and measurement of falls risk
>
> All residents are assessed using InterRAI. Falls risk is determined by a triggered CAP and/or Registered Nurse observation of risk.
>
> **5.2** Falls Risk Management Plan
>
> A personalised fall management plan is developed following assessment and this is documented in the Person Centred Care Plan.
>
> Nursing interventions for those identified with a fall risk may include, although not exclusively:

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- Orientating the resident to the facility on admission
- Ensuring appropriate mobility aids are used
- Ensuring footwear is appropriate, safe and fits properly
- Continually assess the environment to reduce number of obstacles, uneven surfaces and slippery surfaces
- Supervising activities
- Maintaining bed at low level
- Assisting with toileting at regular intervals
- Reminding residents to ask for assistance to transfer
- Assisting residents to transfer
- Regularly assessing what tasks the resident can safely undertake
- Placing at risk residents in rooms close to Nursing Stations
- Ensuring bell is within reach at all times
- Close monitoring at regular intervals — intentional rounding
- Use hip protectors where appropriate and acceptable to the resident

5.3 Resident Falls

All residents who fall must be assessed for injury by the most senior staff member on duty prior to moving their position.

The senior staff member notifies the family/EPOA (adhering to Oceania Health Care Open Disclosure Policy) and the doctor if necessary. An ambulance may need to be called and the resident transferred to hospital.

An Incident/Accident Reporting Form is completed and given to the Business and Care Manager/Clinical Manager.

A Post Falls Assessment is completed to identify contributing factors for the fall and further Corrective Actions to be taken.

Any unwitnessed fall or a fall that involves injury to the resident's head must have neurological observations taken for 24 hours post fall. (refer to neurological observation guidelines). Document fall in progress notes and handover documentation.'

Responses to provisional opinion

Mrs A

72. Mrs A was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion on behalf of Mr B's family, and her comments have been incorporated throughout the report where relevant. She stated that the family have not

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recovered from the treatment that Mr B received from VPRH and that most of the family did not get a chance to say goodbye to him in person. Mrs A believed that the staff at VPRH were trained and experienced staff in nursing elderly patients, and therefore it did not occur to Mrs B to question them.

73. Mrs A said that the family cannot know how things would have gone if Mr B had been kept safe by the staff at VPRH and consider that the staff involved will never appreciate the guilt the family now feel for leaving Mr B at VPRH. Mr B never asked for much for himself, and his only wish was to be able to die at home.

Oceania

74. Oceania was provided with an opportunity to comment on the provisional opinion, and its comments have been incorporated throughout the report where relevant.

75. Oceania stated that it deeply regrets the events outlined in the report and acknowledges the impact Mr B's death has had on his family and apologises that Mr B did not receive the expected standard of care while he was at VPRH.

76. Oceania accepted that there were deficiencies in the care provided to Mr B, particularly on learning of his fall overnight. Oceania accepted that staff did not show respect towards Mr and Mrs B and that there were deficiencies in reporting and documentation in the clinical file, and that the initial falls assessment on admission was inadequate.

77. Oceania stated that since these events, VPRH has had changes to its management, and the region is now overseen clinically by a registered nurse with previous management experience.

RN E

78. RN E was provided with an opportunity to comment on the provisional opinion, and her comments have been incorporated throughout the report where relevant. RN E told HDC that at the time, she was not made aware of the initial complaint made by Mr B's family. She said that neither Oceania's internal investigation, nor the DHB's external investigation involved her or found that she held any responsibility. RN E said that she continued to work with Oceania for one year following the incident, and during that time Oceania management did not question her nursing competence.

79. RN E said that her role was to offer clinical support to staff rather than supervise the care they delivered. She denied that a registered nurse would need supervision from another registered nurse, as both share the same NZ Nursing Council scope of practice.

80. RN E considers that the responsibility should not fall on her personally for any deficiencies in Mr B's care.

RN D

81. RN D was provided with an opportunity to comment on the provisional opinion, and her comments have been incorporated throughout the report where relevant.

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82. RN D told HDC that she is sorry for what happened and expressed her condolences to Mr B's family. She said that going forward, she intends to improve her communication skills in the workplace and be more sensitive to the needs of her residents. She also intends to submit incident reports and do neurological observations regardless of the evidence when a resident claims to have had a fall. She is willing to undergo professional development training as recommended.

RN C

83. RN C was provided with an opportunity to comment on the provisional opinion and did not provide a response.

Opinion: Oceania Care Company Limited — breach

Introduction

84. Mr B was elderly and vulnerable, with multiple comorbidities. He was cared for at home by his wife and entered VPRH for five days of respite care. He and his family reasonably expected that he would receive care of an appropriate standard while he was at VPRH. I take this opportunity to express my condolences to Mr B's family for their loss and acknowledge the distress that resulted from the events.

85. As a healthcare provider, Oceania was responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). In this case, I consider that there were deficiencies in the care several staff members provided to Mr B. Although I am critical of those individuals, as discussed below, I consider that there were broader systems issues at VPRH.

86. The Health and Disability Services (Core) Standards[5] includes the following:

a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

b) Consumers receive timely services, which are planned, coordinated, and delivered in an appropriate manner;

c) Services are managed in a safe, efficient, and effective manner, which complies with legislation; and

d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.

[5] NZS 8134.1.3:2008 current at the time of events. This has since been replaced.

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87. Standard 1.3 requires that consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

88. Standard 2.9 requires that consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. It states:

> 'Criteria
>
> …
>
> 2.9.9: All records are legible and the name and designation of the service provider is identifiable.
>
> 2.9.10: All records pertaining to individual consumer service delivery are integrated.'

89. In my view, VPRH failed to comply with these standards in several regards, as follows.

Falls risk assessment — breach

90. The initial care plan completed on Mr B's admission to VPRH indicated that he was able to walk independently with the use of a walking aid. However, no falls risk assessment was undertaken, and he was deemed not to be a falls risk, despite using a walker for mobilising. There is no indication in the notes as to whether Mr B had insight into his own safety and his ability to mobilise, particularly at night. No short-term nursing goals related to mobility are included as part of the care planning.

91. I obtained clinical advice from a registered nurse, Associate Professor Karole Hogarth, who advised that a falls risk assessment is part of a first assessment when a resident is admitted to a facility, to ensure a baseline and to put strategies in place as necessary to ensure safety. She said that reassessment of the falls risk should occur regularly and is necessary if there is any change in the resident's condition, and after any falls. Although Mr B was admitted for respite care, a falls risk assessment was still essential as part of ensuring his safety.

92. Associate Professor Hogarth said that Mr B's falls risk assessment should have included his complex medical history and his current wellness. The factors specifically related to his falls risk should have included that he used a walking frame for mobility; he had had a stroke previously and had left-sided weakness; he had Parkinson's disease; he was blind in his left eye; he had poor hearing; he had shortness of breath; his polypharmacy had potential side effects; and his age was advanced. She advised that these factors, along with being in a different environment, would have put him at higher risk of a fall.

93. Oceania accepted that Mr B's initial falls assessment was not adequate but noted that he had been receiving respite care with VPRH since 2015, so staff were generally familiar with his mobility and falls risk. However, in my view, given the likelihood of his condition deteriorating over time and the potential for workforce personnel changes, historic information was not sufficient.

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94. Associate Professor Hogarth advised that the lack of a falls assessment was a moderate departure from accepted standards. I agree and consider that Oceania failed to provide services to Mr B that minimised the potential harm to him, in breach of Right 4(4) of the Code.[6]

Response to fall and breathlessness — breach

Fall

95. A healthcare assistant recorded that Mr B slept well overnight on the first night, that two-hourly checks were completed, and that no concerns were voiced. The records do not indicate whether the sensor mat in Mr B's room was in place and turned on during the night.

96. It is documented that in the morning Mr B was washed and changed, but he had only a 'fair' intake of food and fluids. There is no record that he told the staff that he had fallen during the night.

97. When Mrs B visited on the morning of Day 2, Mr B told her about his fall. At about 3.30pm she informed RN D that Mr B had told her that he had fallen during the night, and RN D replied that it had been unwitnessed and suggested that he might have bumped into a doorway. Mrs B pointed out that her husband had bruising on his elbows and forehead, and carpet graze marks on his feet. There is no evidence that RN D discussed the fall with Mr B or asked him what had happened. I accept that Mr B did not have bruising on admission, and the ambulance service record on Day 3 notes that at that stage Mr B showed evidence of bruising on his arms, legs, and head. However, the new bruising is not documented in his VPRH progress notes.

98. Associate Professor Hogarth advised that a fall is of concern for any resident and should be followed up by staff as soon as they are notified, irrespective of whether the fall was witnessed or unwitnessed. In the event of an incident, staff need to respond according to the policies and procedures to ensure that the safety and wellbeing of the resident is maintained. I agree and note that the injuries described are not consistent with the explanation given by RN D.

99. RN D took Mr B's observations, which were normal, although his oxygen level at 94% was lower than his baseline of 99% on admission. She recorded at 3.30pm: 'On assessment, he walks well to the toilet with walking frame, [observations] taken. ROM on upper arms are equal in strength.' RN E then reassessed Mr B and recorded: '[A]ble to present full ROM, denied any headaches and nil other pain. No blurred vision reported. Able to communicate freely without any distress.'

100. No incident report was completed, and neurological observations were not commenced as per the Falls Policy, which required that neurological observations be undertaken for 24

[6] Right 4(4) of the Code states that every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

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hours after an unwitnessed fall. In addition, no Post Falls Assessment was undertaken, as also required by the policy.

101. Associate Professor Hogarth advised that the Falls Policy was appropriate but there was a moderate departure from accepted practice and care of Mr B because the policy was not followed, assessments were not undertaken as expected, and the documentation is incomplete. I accept this advice.

Breathlessness

102. Mrs B was concerned about Mr B's breathlessness, and at 4pm on Day 2 RN C took another set of observations. His oxygen saturation had dropped to 93% and his respiratory rate was 28 breaths per minute, which was significantly higher than on admission. RN C advised Mr B to sit upright in bed and recorded that this had some effect. There is no record of any follow-up after this assessment. The GP was not contacted when Mr B's oxygen saturations dropped and he was short of breath. Oceania accepted that its Oxygen Therapy Policy was not followed.

103. There are no further entries in the progress notes until 3.35pm on Day 3, when there is a record that an ambulance had been called. Oceania told HDC that the handover sheets from the morning shift to the afternoon shift indicate that a further set of observations were taken, and Mr B's BP was lower than previously and his respiratory rate had settled, but his oxygen saturations were also lower than those taken previously.

104. Associate Professor Hogarth advised that in most care facilities oxygen would be used in the case of respiratory or cardiac emergency, and a registered nurse would administer this as required. However, oxygen administration would not be normal practice unless the oxygen saturation and other assessments indicated that this was necessary. Associate Professor Hogarth stated: 'In this instance, following full assessment it may have been prudent to administer oxygen as per the policy if indicated.'

105. The recordings documented on Day 2 are the only set of observations in the records. Associate Professor Hogarth said that it would have been expected that ongoing observations would be undertaken prior to the calls to the ambulance service and during the wait for transport. She advised that there was a moderate departure from the accepted standard of care as the documentation was inadequate and confused, and the observations, follow-up, and monitoring were minimal.

106. In my view, this was poor care. Mrs B had made her concerns clear, had said it appeared that Mr B had had a TIA, and had provided Dr F's letter to VPRH. Mrs B arranged for her daughter-in-law to attend, and it was only after Mrs B's daughter-in-law said that she would take Mr B to hospital herself that RN E called the ambulance service.

107. In my view, the attitude of the VPRH staff added unacceptably to Mr and Mrs B's anxiety and distress. Following Mr B's fall, and in response to his breathlessness, Oceania failed to

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provide services to Mr B with reasonable care and skill and, accordingly, I find that Oceania breached Right 4(1) of the Code.[7]

Record-keeping — breach

108. The VPRH policy regarding the progress notes is contradictory. It indicates that progress notes should be written at least twice a day, during the morning and afternoon shift, whereas the Oceania Resident Admission Checklist states that progress notes must be completed 'within 8 hours [of admission] and each shift thereafter'.

109. Associate Professor Hogarth said that all documentation in a resident file needs to be factual, clear, concise, legible, accurately dated, and timed and consecutive. She advised that normal practice is to complete progress notes at least once each shift, and it would be unusual to write progress notes only twice a day. She said that to exclude the night shift from the policy is not normal practice, especially as many incidents occur overnight and many residents need assistance, such as pain relief, at that time. She advised that the progress notes for Mr B are confusing, and it is difficult to follow the timeline. She noted that the dates and times are confused, and it is only due to the content of the entry that the time can be assumed.

110. Associate Professor Hogarth said that there is a lack of detail or background regarding the fall and Mr B's shortness of breath. The note written on Day 2 at 3.20pm indicates that an incident had occurred and there had been an assessment by the registered nurse, but it is not clear what the incident was.

111. There is an entry in the notes on Day 2 describing Mr B's breathlessness, but there is no follow-up or notes written until 3.35pm on Day 3. Associate Professor Hogarth said that this is a large gap and does not provide any evidence of Mr B's care over 16–17 hours, and there are no entries on an observation chart showing any deterioration of Mr B's condition.

112. RN E said that she called the ambulance because RN G had escalated to her that Mr B was short of breath. Associate Professor Hogarth noted that it is not clear in Mr B's notes why an ambulance was requested, and there is no indication in the notes that he had deteriorated or that there were escalated concerns. Although some observations are documented in the progress notes, they are not noted on an observation chart.

113. Associate Professor Hogarth stated that there was a moderate to significant departure from the accepted standard of care for Mr B related to the confused documentation, lack of documentation of observations, and lack of documented follow-up. I accept this advice.

114. Oceania acknowledged that there is a lack of information in Mr B's clinical records. It accepted that this did not meet its own standards of clinical practice and generally accepted

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

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standards of care. This is not the first time that such issues have been brought to Oceania's attention.[8] In an earlier case, HDC said:

> 'Handover sheets and communication books are not a record of care — all patient information, interventions, and changes in medication should be documented in the Progress Notes. Important information can be lost if not recorded …'

115. The Health and Disability Services (Core) Standards[9] require organisations to ensure that consumer information is 'uniquely identifiable, accurately recorded, current, confidential, and accessible when required'. I consider that VPRH's documentation system did not meet this standard. Accordingly, Oceania breached Right 4(2) of the Code.[10]

Respect — other comment

116. On several occasions, VPRH staff failed to treat Mr B with respect. When Mrs B told RN D that Mr B had fallen during the night, she responded that the fall had been unwitnessed, and when Mrs B said that he had bruising on his elbows and forehead, and carpet graze marks on his feet, she replied: 'We don't know that he has fallen. He could have just bumped into a doorway.' RN D did not ask Mr B what had happened. In my view, this response was dismissive and disrespectful.

117. On Day 3 Mr B was experiencing severe back pain. Mrs B showed the staff the letter written by Dr F in 2018 outlining specific procedures that had been requested by the cardiologist at Hospital 2 should Mr B require medical attention, but this was brushed off. RN C made no comment about whether she was shown the letter. RN E does not recall having seen it and said if she had, a copy would be on the file. Given Mrs B's concern about her husband's condition, I consider it is more likely than not that she at least attempted to draw the letter to staff members' attention.

118. On Day 3 a carer assisted Mr B to the bathroom. She left him sitting on the toilet with no bell and with the doors open, with no privacy.

119. Mrs B told RN E and RN C that Mr B needed help. Mrs B said that RN C replied: 'Oh, I'll give him an antidepressant to calm him down.' However, RN C denies having said this, and RN E said that she did not hear this. Accordingly, I am unable to make a finding as to what was said, but I would be highly critical if such a comment was made.

120. Mrs B said that when she mentioned Mr B's back pain again, RN C asked him to sit up, roughly pulled up his top, poked at his back, and said that there was no bruising. RN C stated that Mr B did not report any back pain to her, and she did not tell Mrs B that he had no

[8] 11HDC00528 (17 January 2014) available at www.hdc.org.nz.

[9] NZS 8134.1:2008, Standard 2.9.

[10] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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bruising on his back. RN C said that she did not observe any bruising on Mr B's arms, legs, or head.

121. However, the ambulance service report that same day states that Mr B reported that he had pain in his lower back at 9/10 on the pain scale when he was moved. The ambulance service record notes that Mr B had bruising on his arms, legs, and head. In light of the ambulance service's observations of Mr B's condition, I find it is more likely than not that Mrs B's account is correct. I do not find RN C's account to be credible.

122. Mrs B said that when the ambulance arrived, the crew immediately attended to Mr B and asked the nurse whether there was oxygen on site. She said the nurse hesitated and said, 'not really, not for this, if you know what I mean?', so the ambulance team brought in oxygen and administered it to Mr B. Mr B had an advance directive stating that he wanted resuscitation and active hospital cares if he became unwell, and I consider this comment to have been disrespectful in light of Mr B's wishes.

123. Although some of these incidents are disputed, and, if they occurred, could be seen to be the actions of individual staff, my view is that management should set a positive culture with residents' wellbeing at the centre, and Oceania failed to do so. As stated by Mrs B, the attitude of staff was 'aggressive, defensive and abusive'.

Opinion: RN E — breach

124. RN E's role included leadership and management, quality systems and audit, taking ownership of the business, human resources, and health and safety. She was required to identify and resolve deficiencies in staff skill and competence. However, by her account she was not aware of any such deficiencies at the time of these events. In response to the provisional opinion, she submitted that her role was to offer clinical support to staff rather than supervise the care they delivered.

125. Despite that submission, I remain of the view that RN E had overall responsibility for the care provided to residents at VPRH. As part of her role, she was required to provide nursing care to residents, address any clinical concerns raised, and ensure that VPRH's clinical and care staff complied with processes, policies, and procedures. In providing care as a registered nurse, she was also required to comply with relevant professional standards.

126. RN E was aware that Mr B had had an unwitnessed fall. Although she assessed him, she did not ensure that an incident report was completed, that neurological observations were commenced as per the Falls Policy, and that a Post Falls Assessment was undertaken, as also required by the policy. Her explanation for this was that each registered nurse is responsible for their own practice and for following up and reporting incidents. She said that she did not review those forms as she had no reason to believe that RN D, as an experienced nurse, would not have completed the necessary reports, notifications, and monitoring. In my view,

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the ultimate responsibility lay with RN E, and she should have checked that the required steps had been undertaken and should have conducted the necessary review of the incident form.

127. On Day 3 Mrs B told RN E and RN C that Mr B needed help. Mrs B asked for a doctor to be called for Mr B. It appears that there was a misunderstanding, as although the VPRH doctor would not attend a respite resident, Mr B remained under the care of his usual GP. I consider that RN E should have intervened at that stage, discussed with Mr and Mrs B the option of contacting their GP, and ensured that Mr B was provided with care of an acceptable standard.

128. Mrs B had made her concerns clear, had said it appeared that Mr B had had a TIA, and had provided Dr F's letter to staff at VPRH. RN E denied having seen the letter. In any event, it was only after Mr B's daughter-in-law said that she would take Mr B to hospital herself that RN E called the ambulance service. RN E said that she did so because RN G told her about Mr B's breathing difficulty and requested that an ambulance be called. In my view, the confusion and delay were RN E's overall responsibility and she should have taken steps earlier.

129. Only one set of recordings is documented, which was on Day 2. There is then a large gap until the following afternoon. Associate Professor Hogarth said that it would have been expected that ongoing observations would be undertaken prior to the calls to the ambulance service and during the wait for transport. She advised that there was a moderate departure from the accepted standard of care due to the lack of and confused documentation, and minimal observations, follow-up, and monitoring.

130. As I have outlined above, it is clear from the information gathered during the investigation that VPRH staff did not complete all the necessary documentation to a sufficient standard. RN E must take personal responsibility for the failures of the staff to keep appropriate clinical records for Mr B.

131. RN E also had responsibility for the clinical care provided to residents by VPRH staff. In my view, she must take responsibility for her failures and the failures of several of her staff to provide appropriate care to Mr B. Accordingly, I find that RN E failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RN C — adverse comment

132. In providing care as a registered nurse, RN C was required to comply with relevant professional standards. However, she failed to follow up on concerns and treated Mr B in a dismissive manner.

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133. At 4pm on Day 2 RN C took a set of observations because Mrs B was concerned about Mr B's breathlessness. His oxygen saturation was 93% and his respiratory rate was 28 breaths per minute, which was significantly higher than on admission. A healthcare assistant recorded that Mr B was short of breath and had a raspy voice. RN C advised Mr B to sit upright in bed and recorded that this had some effect. There is no record of any follow-up after this assessment. RN C said that Mr B's breathing had improved, his range of motion in his arms and legs was good, and he denied having pain. She did not feel that any further assessment was required. She did not reassess Mr B's oxygen saturation or respiratory rate and recorded only that the advice had had some effect.

134. On the morning of Day 3 Mr B was still in pain and breathless. Mrs B said that she told RN E and RN C that Mr B needed help, and RN C replied: 'Oh, I'll give him an antidepressant to calm him down.' RN C said she did not say that, and RN E said that she did not hear this. I am unable to make a finding as to what RN C actually said, but I accept that Mrs B asked for help for her husband, but none was forthcoming.

135. Mrs B asked for a doctor to attend Mr B. She said that RN C told her that this would not happen as the doctors did not come to VPRH. Again, RN C denied that this was what she said. In any event, the GP was not contacted.

136. Mrs B said that when she expressed concern about Mr B's back pain again, RN C asked him to sit up, roughly pulled up his top, poked at his back, and said that there was no bruising. RN C stated that Mr B did not report any back pain to her, and she did not tell Mrs B that he had no bruising on his back. RN C said that she did not observe any bruising on Mr B's arms, legs, or head. It appears that RN C did not ask Mr B whether he was in pain.

137. However, the ambulance service report that same day states that Mr B reported that he had pain in his lower back at 9/10 on the pain scale when he was moved. The ambulance service record notes that Mr B had bruising on his arms, legs, and head. In light of the ambulance service observations of Mr B's condition, I find it more likely than not that Mr B did have pain in his back, as reported by his wife, and he had bruising on his arms, legs, and head. In my view, RN C's assessment was inadequate.

138. I am concerned about RN C's actions. There is no record of any follow-up after her assessment of Mr B at 4pm on Day 2. She did not contact his GP when his oxygen saturations dropped and he was short of breath, and she did not follow the Oxygen Therapy Policy.

Opinion: RN D — adverse comment

139. On Day 2 when Mrs B told RN D that Mr B had fallen during the night, she responded that it had been unwitnessed, and when Mrs B said that she pointed out that he had bruising on his elbows and forehead, and carpet graze marks on his feet, RN D replied: 'We don't know that he has fallen. He could have just bumped into a doorway.' There is no evidence that RN

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D asked Mr B what had happened. RN D told HDC that she does not believe she would have spoken to Mrs B in this way. However, she also provided an apology if she did do so. Although there are varying recollections of what was said, if RN D did make such a response to Mrs B, I consider that it was dismissive and disrespectful.

140. Associate Professor Hogarth said that a fall is of concern for any resident and should be followed up by staff as soon as they are notified, irrespective of whether the fall was witnessed or unwitnessed. In the event of an incident, staff need to respond according to the policies and procedures to ensure that the safety and wellbeing of the resident is maintained.

141. The Falls Management Policy required RN D to complete an Incident/Accident Reporting Form and conduct a Post Falls Assessment to identify contributing factors for the fall and further corrective actions to be taken. Furthermore, she had been informed that Mr B had bruising on his forehead. The Falls Management Policy stated:

> 'Any unwitnessed fall or a fall that involves injury to the resident's head must have neurological observations taken for 24 hours post fall … Document fall in progress notes and handover documentation.'

142. However, no incident report was completed, and neurological observations were not commenced. In addition, no Post Falls Assessment was undertaken. RN D accepts that she did not complete an incident form and said that was because she did not think that Mr B had had a fall.

143. RN D assessed Mr B's observations, which were normal, although his oxygen level had dropped from 99% at admission to 94%. She recorded that he walked well to the toilet with his walking frame and that the range of motion of his upper arms was equal in strength. RN E then reassessed Mr B.

144. I am concerned that RN D failed to respond adequately to Mr B's fall. However, in mitigation, I note that RN E was involved, and ultimately was responsible.

Changes made

145. The following changes have been made at VPRH since the complaint about Mr B's care:

- A nurse practitioner has been employed to support the registered nurses and healthcare assistants at VPRH.
- An eCase client management system has been implemented. This allows better and more detailed reporting and greater oversight of the cares provided to residents.

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- Oceania's Falls Management Policy has been reviewed and now has a flow chart for falls follow-up (as indicated in the Frailty Care Guides).
- There has been a recent review of the neurological observations charting to include Glasgow Coma Scale scoring post falls, and some more guidance in relation to neurological observations.
- Oceania has implemented the STOPANDWATCH tool to assist staff to identify any changes to resident care requirements.
- Oceania has reviewed the Oxygen Therapy Policy. It has conducted clinical training on oxygen use and how to use pulse oximeters correctly. The training was undertaken by a nurse practitioner as part of Oceania's clinical education series, primarily targeted towards clinical managers and registered nurses.
- Oceania has conducted professional development days for registered nurses. These include management of deteriorating residents and clinical documentation.
- A clinical governance review was undertaken by an independent review team. The review focused on organisational policy, organisational structure, systems, staffing, skill mix, and education. A new clinical governance committee was set up, which has oversight of all clinical and care activities within Oceania, and the committee reports to the Board of Directors. This has enabled greater focus and discussion on areas of compliance and quality improvement, with learnings shared across the business.
- Oceania's internal auditing process now includes a whole clinical facility check and rates the facility on a risk level based on the robustness of its clinical systems and processes. The regional clinical managers complete these checks quarterly and oversee the progress of the identified corrective actions.
- eCase training for registered nurses has commenced across Oceania's facilities, which covers resident assessment, care planning, evaluation of care, and specific resident goals and interventions, linking to interRAI triggers and resident acute changes. This will continue to be provided through clinical cluster meetings and the monthly clinical quality education forum.

Recommendations

146. I recommend that Oceania Care Company Limited, RN E, and RN C each separately provide a formal apology to Mr B's family for the criticisms in this report. The apologies are to be sent to HDC within six weeks of the date of the report. RN D has apologised in writing to Mr B's family for the criticisms in the report, and the apology will be sent to the family.

147. I recommend that the Nursing Council consider whether a competence assessment of RN E is required.

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148. I recommend that within three months of the date of this opinion, RN E, RN C, and RN D each undertake training on falls management, communication with consumers, and record-keeping, and report back to HDC with evidence of the content of the training and attendance.

149. I recommend that Oceania Care Company Limited undertake the following, within three months of the date of this opinion:

- Provide training to staff about current documentation policies, and the importance of having a comprehensive and up-to-date record of a resident's care and needs, and provide evidence of that training to HDC.
- Arrange an independent audit of patient records at VPRH to assess compliance with documentation policies and professional standards, and report to HDC on the results of the audit.
- Use this report as a basis for staff training at VPRH, focusing particularly on the breaches of the Code identified, and provide evidence of that training to HDC.
- Review the admission policy and ensure that it includes clear guidance on the requirements for a resident being admitted for respite care. This is to include:
  - An acknowledgment and awareness that residents accessing respite care are among the most vulnerable and high-risk cohort;
  - A full clinical assessment for each admission in order to understand any new clinical issues that have arisen since the previous respite admission, and subsequently develop an appropriate care plan;
  - Clear guidance on how to access timely nurse practitioner/GP support when required, including the responsible clinician for this group of residents; and
  - A documented process to guide pre-admission, eg, a checklist for managers and nursing staff to ensure that all required information is collected in a consistent manner.

Follow-up actions

150. A copy of this report with details identifying the parties removed, except the advisor on this case, Oceania Care Company Limited, and Victoria Place Rest Home and Hospital, will be sent to the Nursing Council, and it will be informed of RN E's name.

151. A copy of this report with details identifying the parties removed, except the advisor on this case, Oceania Care Company Limited, and Victoria Place Rest Home and Hospital, will be sent to HealthCERT, Te Whatu Ora|Health New Zealand, and Te Tāhū Hauora|the Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from registered nurse Associate Professor Karole Hogarth:

> 'HDC REPORT REFERENCE: C20HDC02116 COMPLAINT: [Mr B]/VICTORIA PLACE REST HOME
>
> Thank you for the request to provide clinical advice regarding the complaint from the family of [Mr B] concerning the care delivered at Victoria Place Rest Home [during his stay]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I registered as a nurse in 1989. Upon registration I was appointed to a new graduate position at Hospital 2 and worked in orthopaedics, surgical and post-natal wards for the first year. I then received a permanent position in the burns and plastics unit at Hospital 2. Following 2 years' experience in this environment I moved to Saudi Arabia in 1992 working as an RN in the Burn Unit in Dhahran. Upon completion of my contract, I moved to England and worked as an RN for an agency providing nursing care in hospitals and community settings. I then moved into a permanent night shift position at BUPA Hull and East Riding, a private hospital in a small community in 1995. On return to New Zealand in 1998 I attended the University of Otago undertaking a combined degree in Zoology and Anatomy completing First Class honours in both in 2001. I worked as an RN in Dunedin at Redroofs Rest home as an RN and casual as a RN at Dunedin Public Hospital during this time. Following the completion of my undergraduate degree I was invited to enrol in a PhD which I did following a further year of travel where I worked as an RN for the Australia blood service in Sydney. While undertaking my PhD in 2004 I was appointed to an academic role 2 days a week at Otago Polytechnic teaching anatomy to Occupational Therapy students. I then expanded my teaching into Bioscience for Nursing and Midwifery students. My PhD research looked at the role of oxytocin in the development and progression of prostate diseases which I completed in the Anatomy Department at the University of Otago in 2009. I was then offered a full-time position in the School of Nursing at Otago Polytechnic teaching sciences. My current role is Associate Professor and Head of Nursing. I am a Justice of the Peace for New Zealand having completed the requirements for this role in 2016 and reaccreditation in 2018 and am on the Otago Polytechnic Ethics committee for Auckland and Dunedin campuses.
>
> The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr B] at Victoria Park Rest Home was reasonable in the circumstances and why. With particular comment on: The adequacy of [Mr B's] falls risk assessment. Please comment specifically on whether you would consider [Mr B] would have been at risk of falling; The adequacy of the actions and assessments undertaken following [Mr B's] fall on [Day 2]. Please comment specifically on follow-up, monitoring and whether actions taken were in line with Victoria Park Rest Home's falls management policy.

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The adequacy of the actions and assessments undertaken in response to reports of [Mr B's] breathlessness on [Day 2]. Please comment specifically on oxygen therapy, escalation of care, follow-up and monitoring; The adequacy of documentation during [Mr B's] admission to Victoria Park Rest Home; The adequacy of the Falls Management policy; Any other matters in this case that warrant comment. For each question I am asked to advise: What is the standard of care/accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be? How would it be viewed by my peers? Recommendations for improvement that may help prevent a similar occurrence in the future.

In preparing this report I have reviewed the following documentation: Letter of complaint dated 16th November 2020; Victoria Park Rest Home's response dated 15th December 2020; Clinical records from Victoria Park Rest Home covering the period [Day 1 to Day 3]; Clinical records from [the ambulance service] covering [Day 3].

Background [Mr B] had significant medical conditions, including severe aortic stenosis, heart failure, Parkinson's disease, recurrent transient ischaemic attacks (TIAs) and associated weakness, shortness of breath, hypertension, poor hearing and was blind in his left eye. [Mr B] was admitted to Victoria Park Rest Home on [Day 1] for a short period of respite care and according to documentation, was not deemed to be a falls risk. However, a sensor mat was in [Mr B's] room. On [Day 2] in the early hours of the morning, [Mr B] suffered a fall. He reported this to his wife, who alerted staff, and a registered nurse undertook an assessment at 3.30pm on [Day 2]. Later that evening at approximately 10.38pm, [Mr B] was reviewed again by an RN due to his breathing. There is a gap in the documentation between [Day 2] at 10.38pm and [Day 3] at 3.35pm. On [Day 3] at 3.35pm, staff called an ambulance to transfer [Mr B] to hospital. [Mr B] was admitted to hospital [where he died two weeks later]. My comments are confined to the care provided by Victoria Park Rest Home.

The adequacy of [Mr B's] falls risk assessment. Please comment specifically on whether you would consider [Mr B] would have been at risk of falling.

a. What is the standard of care/accepted practice? Falls risk assessment is part of a first assessment when a resident is admitted to a facility to ensure a baseline and to put strategies in place as necessary to ensure safety. Reassessment of falls risk should occur regularly, if there is any change in the resident's condition and after any falls. As this admission was for respite, falls risk assessment was still essential as part of ensuring resident safety. [Mr B's] falls risk assessment would have included his complex medical history and his current wellness. Known considerations specifically related to his falls risk as indicated in his notes should have included: He used a walking frame for mobility; Previous CVA with L) sided weakness; Parkinson's disease; Blindness L) eye; Poor hearing; Shortness of breath; Polypharmacy and potential drug side effects (e.g., all of these drugs can cause dizziness — amlodipine, clonazepam, olanzapine, pramipexole); Advanced age. These factors would have put him at higher risk of a fall as well as being in a different environment. It was indicated on admission that he mobilised

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independently with his walker but there is no further information regarding his falls risk assessment. There was no indication in the notes as to whether [Mr B] had insight into his own safety and ability to mobilise especially at night. There were no short-term nursing goals related to mobility as part of care planning in the information provided for this review. It is indicated that a falls mat was in [Mr B's] room though possibly had been moved under his bed during the day. Am unsure why the mat would have been in his room if he were not deemed a falls risk, possibly a mat is standard in rooms at this facility.

If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be? From the information given I would consider that there is a moderate departure from accepted practice and care of [Mr B]. This is due to the lack of documented specific falls assessment on admission and no evidence of consideration of his complex health needs that may have impacted on his mobility. Added to this is the potential for disorientation of a new environment, needing to mobilise at night and the query as to whether the falls mat was in place and/or working.

How would it be viewed by my peers? I believe that my peers in practice and education would agree that there was a gap in the review of falls risk assessment which does not meet the accepted standard of care.

Recommendations for improvement that may help to prevent a similar occurrence in the future. Victoria Place Rest Home and Oceania have made a number of changes to their procedures including an updated falls policy to streamline the flow chart, implementation of auditing and further staff education; these are positive steps. For respite care residents there needs to be a clear pathway for assessment at admission and ongoing during their stay that is robust and thorough. Ongoing regular in-service for ENs and HCAs on the assessment of falls risk, monitoring, maintain mobility in the elderly and the importance of exercise for balance and strength. The importance of accurate documentation in regard to falls management is recommended.

7. The adequacy of the actions and assessments undertaken following [Mr B's] fall on [Day 2]. Please comment specifically on follow-up, monitoring and whether actions taken were in line with Victoria Park Rest Home's falls management policy

a. What is the standard of care/accepted practice? A fall is of concern for any resident and should be followed up by staff if it was witnessed or unwitnessed. Many falls in care are unwitnessed and can be the most difficult to assess especially assessing the potential for injury. These rely on the information from the resident and should be considered carefully and followed up as soon as notified. The role of staff in this is to support, assess and provide treatment as needed. In the event of an incident staff need to respond according to policy and procedure to ensure that the safety and wellbeing of the resident is maintained, and this includes communication with the family. In regard to the fall on the night of [Day 2] disclosed by [Mr B]: No indication from the night shift notes that a fall occurred, 2 hourly checking noted. No indication if the falls mat in

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[Mr B's] room was in place and on. [Mr B] complained of back pain in the afternoon following, and there was no indication if the cause was discussed with him. [Mr B] told his wife he had fallen when she visited in the afternoon, and she informed staff [Mr B] stated he could not reach the call bell for assistance when he fell. No incident report was completed. Neuro observations were not commenced as per the policy. No evidence of Post Falls Assessment as per the policy. A Falls policy should clearly include a process for following up falls, witnessed and unwitnessed. The Victoria Place Rest Home Falls policy requires that neurological observations be undertaken for 24 hours post an unwitnessed fall, but this was not done.

There are a couple of queries from this: Where was the call bell that [Mr B] could not reach it? Would it be normal practice at this facility to check on new admissions more regularly the first few nights? What was the purpose of the sensor mat in the room if [Mr B] had not been assessed as a falls risk? Why was an incident form not completed and given to the Clinical Manager? Was a post falls assessment completed to identify cause and corrective actions? Mr and Mrs B expressed their worry over the fall and have stated that they felt their concerns were dismissed by staff on shift. As per the Falls policy there should have been an injury assessment including 24 hours of neurological observations and post falls assessment.

It is noted by the ambulance staff on [Day 3] that [Mr B] showed evidence of bruising on his arms, legs, and head, but this had not been documented in his progress notes.

If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be? From the information given I would consider that there is a moderate departure from accepted practice and care of [Mr B]. The policy for an unwitnessed fall was not followed and assessments were not undertaken as expected and documentation is incomplete.

How would it be viewed by my peers? I believe that my peers in practice and education would agree that the documented actions do not meet the accepted standard of care.

Recommendations for improvement to prevent a similar occurrence in the future. Victoria Park Rest Home and Oceania have made improvements to their processes around falls management as above. I would suggest that there is an addition to the policy covering respite care residents to ensure that normal admission assessments are undertaken to the same extent (with the exception of InterRai unless admitted for over three weeks). A care Plan should include all aspects of care especially those related to patient safety. It would be useful in the progress notes to ensure that if there has been an incident within the last 48 hours that follow-up of this is noted in the progress notes. This will show continuity of care as issues may arise over time e.g., bruising, immobility, increased pain.

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The adequacy of the actions and assessments undertaken in response to reports of [Mr B's] breathlessness on [Day 2]. Please comment specifically on oxygen therapy, escalation of care, follow-up, and monitoring.

a. What is the standard of care/accepted practice? Oxygen may be available in care homes for use in emergencies or for those that require long term oxygen therapy. If a facility has supplies of oxygen for emergency use:

There must be an oxygen administration policy

It must indicate in nursing care plans who can have oxygen administered

Staff must be competent and have appropriate training especially around the administration and monitoring of the effects of oxygen.

A pulse oximeter should be used to monitor the effects of oxygen administration.

A risk assessment should be completed as part of a standard operating procedure or policy.

In most care facilities oxygen would be used in the case of respiratory or cardiac emergency and would need the RN to administer this as required. Administration would not be normal practice unless SaO_2% and other assessments indicated that this was necessary. In this instance, following full assessment it may have been prudent to administer oxygen as per the policy if indicated. It is not clear in [Mr B's] notes as to why an ambulance was rung and there is no indication in the notes that he had deteriorated or that there were escalated concerns. Part of this may be due to the progress notes not flowing and the timelines being confused. There are some observations documented in the progress notes though observations were not noted on an observation chart with only one set of recordings on [Day 1] documented. Given that an ambulance was called it would be expected that ongoing observations would have been indicated prior to this and during the wait for transport.

If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be? From the information provided I would consider that there is a moderate departure from the accepted standard of care. This is due to the lack of and confused documentation, minimal observations and follow-up and monitoring not meeting accepted standard.

How would it be viewed by my peers? I believe that my peers in practice and education would agree that this incident and the way it was managed do not meet the accepted standard.

Recommendations for improvement to prevent a similar occurrence in the future. It is essential that there is a consistent approach to the escalation of care. There have been some changes made by Oceania to improve the assessment, intervention and planning of care which include the use of assessment tools and further education including the frailty guidelines and early warning assessment. Implementation of early warning

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scores will assist in the assessment of deterioration of residents and provide reassurance to families.

9. The adequacy of documentation during [Mr B's] admission to Victoria Park Rest Home.

a. What is the standard of care/accepted practice? It is expected that a new resident would be fully assessed on admission as per the facility requirements. This would include a range of assessments some of which should occur at the time of admission e.g., safety, mobility, falls and others that can occur over the next 24 hours or longer such as the InterRai which in most facilities needs to be undertaken within 3 weeks of admission. All documentation in a resident file needs to be factual, clear, concise, legible, accurately dated, and timed and consecutive. These are legal documents and may be viewed by any person involved in the healthcare of an individual and as part of a case.

Normal practice is to complete progress notes at least once each shift. The Victoria Place Rest Home policy indicates that notes should be written at least twice a day — am and pm shift — though on the Oceania Resident Admission Checklist it states that progress notes must be completed "within 8 hours and each shift thereafter". It would be unusual to only write progress notes twice a day and why this would exclude night shift is not normal practice especially as many incidents occur overnight and many residents need assistance, pain relief, etc.

The progress notes for [Mr B] are confusing. On first reading it appears that there is a large gap in the timeline of documentation. It is difficult to follow the timeline. It should not be up to the reader to decipher the timeframe or the meaning behind any entry. Dates and times are confused and it is only by the content of the entry that the time can be assumed.

There is a lack of detail or background regarding the incidences — fall and shortness of breath. The note written on Day 2 at 1520 indicates an incident and an assessment by the RN but is not clear what the incident is.

There is an entry in the notes dated [Day 2] 2238hrs, describing [Mr B's] breathlessness, but there is no follow up or notes written until 1535 on [Day 3]. This is a large gap and does not provide any evidence of [Mr B's] care over the following 16–17 hours. As stated above there are no entries on an observation chart showing any deterioration of [Mr B's] condition.

If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be? From the information provided I would consider that there is a moderate to significant departure from the accepted standard of care for [Mr B] related to the confused documentation, lack of observations documented and their follow up.

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How would it be viewed by my peers? I believe that my peers in practice and education would agree with my assessment that the documentation does not meet the accepted standard of care due to the confused timelines and the lack of observations documented following resident deterioration.

Recommendations for improvement to prevent a similar occurrence in the future. Regular education would be recommended regarding accurate and clear documentation. Observation charts must be completed where a resident deteriorates.

The adequacy of the Falls Management policy.

What is the standard of care/accepted practice? All facilities should have robust policies to ensure that there is a framework for staff to follow. A good policy should guide in achieving the objectives for the scenario (e.g., falls management, manual handling) and it should provide a broad outline of the facility requirements and leave scope for some decision making by staff. Guidelines can be included, and it should be clear who has responsibility for the care, treatment and follow-up, including documentation. Procedures can also be included as appendices to be used on a day-to-day basis in patient care. A flow chart can be very useful for staff to follow and to have consistency of responses. The Falls policy included in this review is brief but adequate and provides a good structure with guidance for staff. It is noted in the response by Oceania that there is a flow chart for falls management (though this was not included) and that it had been streamlined.

If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be? From the information given I would consider that there is no departure from accepted practice in the falls management policy.

How would it be viewed by my peers? I believe that my peers in practice and education would agree with my assessment that the policy meets the accepted standard of care.

Recommendations for improvement to prevent a similar occurrence in the future. No recommendations.

Review completed by: Associate Professor Karole Hogarth JP, RN, BSc, PhD

9th April 2021."

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