Prasad Family Foundation Limited (trading as Brylyn Residential Care)

Nurse Manager, Ms A

Registered Nurse, Ms B

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC00571)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In January and February 2012, Mrs C was a long-term resident at Brylyn Residential Care (Brylyn). She had chronic low back pain, and was receiving ongoing opiate pain relief. Mrs C also had osteoporosis, some cognitive impairment, and progressive dementia. She required full assistance for personal cares. She walked with a mobility frame.

2. On 15 January 2012, a reddened area on Mrs C's back was identified. Nurse Manager (NM) A considered that the redness was pressure related. No short-term care plan was instigated on that day or on 18 January when a urinary tract infection (UTI) was suspected.

3. On 21 January, the registered nurse on weekend duty, RN B, reviewed Mrs C. Mrs C was transferred to the public hospital (the hospital) because of her increased back pain. The hospital assessment resulted in a prescription for continued opiates and three days of diazepam. RN B later transcribed the hospital prescriptions onto Brylyn medication administration charts. RN B applied a Duoderm dressing to the wound on Mrs C's back but did not start a short-term care plan or record the size of the wound or describe the grade of the wound.

4. On 24 January, Mrs C slipped to the floor while walking with her mobility frame. Her fall was broken by two staff. NM A completed an incident form. Follow-up was scheduled for 27 January, when general practitioner Dr F was due to visit.

5. On 26 January, Mrs C fell again. NM A examined Mrs C and instigated short-term and pain management care plans, but documented few instructions for staff to follow.

6. On 27 January, Dr F reviewed Mrs C. NM A did not advise Dr F of Mrs C's falls.

7. Handover of residents' care and communication with care staff usually took place via a staff communication book, resident progress notes, and a handover sheet.

8. NM A and RN B did not usually see each other in person. Handover between the Nurse Manager and registered nurse roles was not formalised or governed by a facility policy. Communication between the Nurse Manager and registered nurse was usually performed by use of an RN communication book.

9. NM A did not communicate to RN B in the RN communication book or in person that Mrs C had fallen on 24 and 26 January.

10. NM A went on leave on 28 January and was due to return on 7 February. RN B did not review or familiarise herself with Mrs C's file, incident reports, or handover sheets prior to providing nurse manager cover for 10 days.

11. On 1 February 2012, RN B reviewed Mrs C. RN B noted that Mrs C had new bruising and her left leg was "dragging" but she could not identify a cause. RN B did not consider a fracture as the cause of Mrs C's pain. RN B did not seek advice from Dr F or the hospital, and did not advise the family of Mrs C's bruising.

12. On 2 February, a visiting physiotherapist assessed Mrs C. The physiotherapist observed that Mrs C's left leg was laterally rotated and shortened, and considered that Mrs C had a recent hip fracture. Mrs C was transferred to hospital by ambulance. A

fracture of the neck of femur was diagnosed. The hospital noted and treated the pressure area wound on Mrs C's back.

Findings

13. NM A did not utilise short-term care plans for pressure management of Mrs C's spine or a suspected UTI. No pain chart was used in conjunction with the Pain Management Plan formulated after Mrs C's second fall on 26 January. Limited guidance was given to staff regarding Mrs C's reduced mobility, why her urine should be checked, and the management of constipation. Appropriately skilled assessments of treatment efficacy were not consistently carried out. NM A did not provide services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

14. It was found that NM A did not advise Dr F about Mrs C's falls. In addition, the informal and indirect nature of handover communications between NM A and RN B, in tandem with infrequent use of short-term care plans, meant that important information about changing clinical circumstances was not provided to RN B adequately. This contributed to a lack of continuity in Mrs C's care. Accordingly, NM A breached Right 4(5) of the Code.[2]

15. RN B failed to review and familiarise herself appropriately with Mrs C's clinical situation. RN B's assessment, evaluation and response to Mrs C's bruising and dragging of her leg on 1 February 2012 were not adequate. RN B failed to provide services to Mrs C with reasonable care and skill and, therefore, breached Right 4(1) of the Code. RN B did not complete an accurate wound description, wound chart and short-term wound care plan. These actions did not comply with professional standards and, accordingly, she breached Right 4(2) of the Code.[3]

16. Brylyn's owner/operator, Prasad Family Foundation Ltd, did not take sufficient steps to ensure that appropriate systems, policies and guidelines were in place to provide services to Mrs C with reasonable care and skill. Therefore, it breached Right 4(1) of the Code.

Complaint and investigation

17. HDC received a complaint from Ms D regarding the care provided to her mother, Mrs C, at Brylyn Residential Care. The following issues were identified for investigation:

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."
[3] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

- *Whether appropriate treatment and care was provided to Mrs C by Prasad Family Foundation Limited trading as Brylyn Residential Care between 15 January and 2 February 2012.*
- *Whether appropriate treatment and care was provided to Mrs C by NM A between 15 January and 2 February 2012.*
- *Whether appropriate treatment and care was provided to Mrs C by RN B between 15 January and 2 February 2012.*

18. An investigation was commenced on 21 May 2013. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

19. Information was received from:

NM A	Nurse Manager
RN B	Registered nurse
Mrs C	Consumer
Ms D	Complainant, Mrs C's daughter
Ms E	Physiotherapist
Brylyn Residential Care	Rest home provider
Dr F	General practitioner
District Health Board	Provider

Also mentioned in this report:

Dr G	General practitioner
Dr H	ED registrar
Ms I	Caregiver

20. Independent nursing advice was obtained from Ms Julia Russell, Registered Nurse (**Appendix A**).

Information gathered during investigation

Background

21. Between December 2009 and April 2010 Mrs C (then aged 75 years) resided at Brylyn Residential Care (Brylyn) for periods of respite rest home-level care. Brylyn's owner/operator is Prasad Family Foundation Limited. A decision was made for Mrs C to stay at Brylyn long term, and this was approved in May 2010.

22. At the time of her admission to Brylyn, Mrs C suffered from chronic lower back pain and was receiving ongoing daily opiate pain relief, OxyContin and OxyNorm.[4] Mrs C has osteoporosis, some cognitive impairment, and memory loss stemming from

[4] Opioid analgesics used to relieve moderate to severe persistent pain.

progressive dementia. In May 2010, the long-term care plan on file noted that Mrs C had dementia but was "sharp" in some instances, and was encouraged to make her own decisions. She required full assistance for personal cares and walked with a mobility frame.

23. From March 2011 onwards, Mrs C had a more shuffling gait while using her mobility frame. Mrs C's opiate medication was maintained but she frequently complained of back pain.

Brylyn Residential Care

24. Brylyn[5] provides rest-home level care for a maximum of 32 residents. Brylyn does not have a Facility Manager position but does have a Nurse Manager position, which at the time of the events complained of was held by registered nurse NM A.[6] The Nurse Manager is relieved at weekends by another registered nurse. At the time of the events complained of, the registered nurse[7] was RN B — a nurse with over 40 years' experience.

Staffing

25. On weekday morning shifts, the Nurse Manager was on duty alongside three caregivers, a cleaner, a cook, and an activities person. The Nurse Manager finished her shift at around 4pm, at which time the caregivers took over.

26. In the afternoons there were two caregivers and a kitchen person on duty, but no registered nurse. As a rest home-level care provider, Brylyn is not obliged to have a registered nurse on duty 24 hours, seven days a week, but a registered nurse was on call overnight (until 7am the next morning), and this on-call duty was shared between the Nurse Manager and the registered nurse.

27. On the morning shift during the weekend, RN B, three caregivers and a cook were on duty. RN B's shift was generally from 7am to around 1–1.30pm, after a lunchtime medication round. At nights there were two caregivers on duty.

Enduring power of attorney status

28. At the time of the events complained of (January–February 2012) Ms D, Mrs C's daughter, was nominated as Mrs C's enduring power of attorney (EPOA) for personal care and welfare and property.[8] The EPOA document had been drawn up on 20

[5] Brylyn receives private funding as well as funding from the DHB and the Ministry of Health.
[6] One function of the Nurse Manager role outlined in the job description provided to HDC states: "Analyse, develop and maintain an effective and efficient nursing care delivery system that reflects patient and family needs across the continuum; achieving desired outcomes (incorporating best practice)."
[7] The registered nurse job description states: "The Registered Nurse has the overall responsibility and accountability for all medical practices occurring at Brylyn Residential Care."
[8] A copy of the EPOA was provided to HDC.

August 2008, but was not invoked by a health practitioner's medical certificate of incapacity until 13 March 2012.[9]

29. NM A told HDC that Mrs C had dementia and did not remember many things, but that she was capable of communicating what she wanted (eg, toilet requests, showering times, eating, etc) and knew her own mind regarding day-to-day activity decisions. NM A felt that Mrs C was not able to grasp issues such as financial ones. Brylyn staff sought input from Mrs C regarding her care and wishes.

30. Brylyn did not provide HDC with any policy or process outlining steps to be taken for staff to ascertain and discuss EPOA status with residents and their families. NM A said that in practice such discussions do occur, and that it is usual practice to notify family members of any incident or any changes in a resident's health. Usually Brylyn would notify one particular family member. During the events complained of, Brylyn would usually contact Ms D regarding Mrs C's condition.

Care provided to Mrs C

31. In January 2012, Mrs C's prescribed medication included OxyContin 5mg twice a day, and OxyNorm 5mg. From the Medication Administration Record, it seems that this was administered in accordance with the prescription. Mrs C was also prescribed paracetamol 20ml four times a day, as required.

15–17 January 2012

32. On Sunday 15 January 2012, Mrs C complained of back pain. That afternoon, paracetamol and a wheat bag were used for pain relief. It was recorded in the progress notes that Mrs C had a reddened area on her back where the wheat bag had been placed. A caregiver filled in an Incident Report form.

33. On Monday 16 January 2012, NM A reviewed the reddened area on Mrs C's back. NM A recorded in the follow-up section of the Incident Report form: "I think the redness is a result of pressure (she is rather thin and bony over the spine). It doesn't appear to be a burn as suspected." No short-term care plan was instigated regarding prevention or management of pressure areas for Mrs C's spine. According to the Medication Administration Record, paracetamol was administered at 2pm and again at 5pm. Mrs C took paracetamol once on 17 January at 3.30pm.

18 January 2012

34. Mrs C had continued back pain. She was incontinent overnight, which was unusual for her. Mrs C also had a mild temperature (37.4°C).[10] At 2.45pm NM A sent a fax to a medical centre (addressed to Dr G, as Mrs C's usual general practitioner (GP), Dr F, was unavailable that day) requesting a visit or a prescription for antibiotics for Mrs C.

35. NM A noted in her fax:

[9] A copy of the certificate was provided to HDC. The consultant psychiatrist's certificate cited that Mrs C's incapacity to make safe decisions about her care was due to progressive dementia.
[10] Normal human body temperature is generally below 37°C.

> "[Mrs C] has been c/o [complaining of] severe back pain over the last couple of days — not relieved by Panadol.[11] (She is already on oxycontin [and] oxynorm). She has also been incontinent of urine (she is normally continent). I now suspect she has a UTI but have not managed to get a sample … I was wondering if someone could come and see her please or alternatively prescribe [and] fax antibiotic script to … pharmacy."

36. Dr G arranged a prescription, and antibiotics were commenced.

37. According to the Medication Administration Record, Mrs C had four doses of paracetamol between 12.30pm and 8.30pm on 18 January.

38. No short-term care plan was established for Mrs C's suspected UTI. NM A told HDC that no plan was started because it had not been established that Mrs C had a UTI prior to commencement of antibiotics. NM A said that "[r]equesting a script for antibiotics was done in an attempt to relieve back pain if in fact this was caused by an infection". Staff were advised via the progress notes to continue paracetamol every four hours and encourage fluids.

39. Communication between NM A and RN B was usually performed through the use of an RN communication book. Communication with other staff, such as carers, was aided by the use of a staff communication book.

40. NM A wrote in the staff communication book:

> "[Mrs C] has been unwell this week with back pain ?UTI. I will drop a sample into lab Friday after work. She has been on antibiotics [and] Panadol Elixir."

41. A caregiver recorded that she required the help of another caregiver to assist with Mrs C's wash and bed cares, on account of Mrs C's back being very sore.

19–20 January

42. Overnight, two caregivers were required to assist with toileting as Mrs C was complaining of being in a lot of pain. According to the progress notes, paracetamol was administered at 12.30am, but this is not recorded in the Medication Administration Record. A further four doses of paracetamol were given between 4.30am and 8.00pm. On 19 January 2012, NM A recorded in the progress notes:

> "[P]ain relief has been given as per medication chart … Unable to get urine sample [at] this stage … [Complaining of] constipation … given lactulose … needs encouragement with food [and] fluids … Appears slightly improved since yesterday."

43. On Friday 20 January 2012 a urine sample was taken but this was not recorded in Mrs C's progress notes. The sample was taken after antibiotics had commenced. Urine testing revealed no infection. That evening, Mrs C had further constipation and was again given lactulose.

[11] A brand of paracetamol.

21 January

44. According to the medication administration records, Mrs C received one dose of paracetamol at 5am on Saturday 21 January, whereas the only record in the progress notes for that shift is "Slept well". That day, Mrs C's antibiotics were completed, but her back pain increased and she was noted to be walking slowly. RN B recorded that Mrs C's lower back was rubbed and that she had contacted Ms D for some Anti-Flamme.[12] RN B also recorded the application of a Duoderm (dressing) for a raw area on Mrs C's spine. This is the first mention of any type of redness or rawness on Mrs C since the incident form of 16 January. No short-term care plan was put in place for managing the area.

45. In response to the provisional opinion, NM A stated:

> "I regret not starting a short term care plan for the reddened area on [Mrs C's] spine or the suspected urinary tract infection but at the time I believed the slight reddened area to be just that, 'slight', and the suspected urinary tract infection to be just that, 'suspected'. At this stage, [Mrs C] was still mobile, continent, and eating regular meals and which led me to believe that she wasn't at risk of a breakdown … In such circumstances it would not be usual to implement a short term care plan but rather to give instructions to staff in the progress notes and communication book. … It would be more appropriate for a short term care plan to be set in place when changes occurred …"

46. A caregiver recorded in the progress notes that after lunch Mrs C refused paracetamol and requested morphine instead. There is a further note that, at 2.30pm, she took two Panadol. It appears that this was in tablet rather than liquid form. There is no record of this on the Medication Administration Record.

47. Ms D told HDC that when she visited that weekend, her mother was in a lot of pain.

48. RN B was on call that weekend. The senior caregiver telephoned her at home and called her back to Brylyn at around 2.15pm because of Mrs C's increased back pain. At around 3pm, after a discussion with Ms D, who had raised concerns about her mother's back pain, RN B decided to have Mrs C assessed at the Emergency Department (ED). Mrs C was transferred to hospital by ambulance.

Hospital ED assessment

49. In ED, Mrs C underwent an X-ray of her lumbar spine, which showed degenerative changes. On assessment, no acute hip fracture, dislocation, or bony injury were noted in the spine. No numbness or weakness was observed, and Mrs C was able to perform a bilateral straight leg raise. The impression noted by the ED registrar, Dr H, was one of musculoskeletal pain.

50. Mrs C's OxyContin was increased to 10mg twice a day, and the OxyNorm to 5mg four times a day, as required. Three days of diazepam was added to her medication regimen. She was discharged back to Brylyn approximately three hours later,

[12] A herbal cream used to relieve lower back pain.

returning at 6pm. GP and physiotherapy follow-up was recommended. A prescription for OxyNorm and OxyContin was completed and signed by Dr H at the hospital.

51. RN B documented in the progress notes that Mrs C had been assessed at the hospital, and noted the outcome, including the alterations to Mrs C's medication. RN B also left a message for NM A in the RN communication book.

52. Later that day, RN B transcribed[13] the hospital prescription medication and dosage on to the Brylyn medication administration charts, identifying that the prescribing had been done at the hospital. The entries record, in the space marked for a doctor's signature, "[Dr H, the public hospital]" and, in the case of the short-term diazepam, "[Dr H] ([initials of the public hospital].)".

53. A copy of Dr H's prescription was attached to the Brylyn medication charts. NM A said that she was aware of the transcribing and acknowledged that this was not best practice, but said that this was done so that staff had a place on the medication chart to sign when the medication was given.

54. On Sunday 22 January, RN B documented that Mrs C continued to complain of pain.

55. On Monday 23 January, staff observed that Mrs C's mobility had altered, and she had become unsteady. The progress notes record: "[Mrs C] refused shower had body wash repeating and telling caregivers her pain is very sore: unsteady walking used wheelchair to move from dining room." No unsteadiness had been noted prior to this.

First fall — 24 January

56. The progress notes for the morning of Tuesday 24 January 2012 included: "[Mrs C] still complaining of back pain. She walks good when no one is watching and tends to be unsteady and groaning when people are around."

57. At 1pm on Tuesday 24 January 2012, Mrs C, while walking with her frame, slipped to the floor. The landing was described as gentle, as two staff, including NM A, were on hand to break the fall. NM A examined Mrs C. NM A told HDC that she performed an assessment to check for shortening or rotation of Mrs C's legs. An incident form was completed by NM A. Mrs C was assisted to walk back to her room. NM A recorded the fall in the progress notes. It was noted on the incident form that Mrs C had no injuries, and that she was not very co-operative with walking. Ms D was not informed of the fall.

58. Dr F was scheduled to visit Brylyn on Friday 27 January. Follow-up of Mrs C was scheduled for that date and noted on the follow-up section of the incident form.

59. NM A's entry in the follow-up section of the incident report (dated 24 January) states: "[T]o be seen on Friday 27th for review of medication," and "Review prn[14] [and] by

[13] See paragraphs 116–117 for an explanation of this practice.
[14] As required.

GP on Friday." The section of the incident form headed "Care plan amended Yes/No" has "No" circled.

60. According to Brylyn policy in place at the time of the events complained of,[15] all incident/accident forms were "to be shown to the doctor on his visits if it was not necessary for her/him to visit the resident immediately, so he/she could follow-up with a visit".

Second fall — 26 January

61. At 11.30am on Thursday 26 January 2012, a caregiver witnessed Mrs C have another fall, as she stood up and started to walk to a table. The caregiver completed an incident form and asked NM A to assess Mrs C, who had sustained a small skin tear to her left wrist.

62. NM A told HDC that when she examined Mrs C, she sat her upright, placed her legs out and put her feet together, and there was no obvious rotation or shortening. NM A then raised Mrs C's legs up and down and asked her if she had pain. Mrs C replied that she did not have any pain other than her usual back pain. NM A was comfortable at that stage that there was no hip fracture. Mrs C was able to walk afterwards. NM A said that she did not call Mrs C's GP, as he was scheduled to visit the following day. Ms D was advised about this fall.

63. NM A documented in the progress notes: "[H]ad fall at 11.30am. Small skin tear [left] wrist. No other obvious injury …" In the follow-up section of the incident form she noted: "Pain management plan in place."

64. After Mrs C's second fall, NM A put in place a pain management plan, which suggested using a pain scale of 1–10. The document detailing the plan combines two headings: "Pain Management Plan" and "Short Term Care Plan" (the combined plan). However, no pain chart was created to record or monitor Mrs C's pain. The combined plan includes an instruction for staff to assess the location of Mrs C's pain.

65. In addition, the combined plan covers interventions associated with various "options for relief" of pain, and assessment of other "holistic" care (encouraging food and fluids, checking urine as required, checking skin for any pressure areas), with an instruction to "report and treat". The combined plan did not detail when or why Mrs C's urine should be checked.

66. Although constipation was listed as an issue in Mrs C's longer term care plan, there is no documented information on the combined plan about what actions should be taken regarding constipation, in the context of Mrs C's increased narcotic use, decrease in mobility, and decrease in food intake. It is recorded on the combined plan that the plan should "be evaluated at least weekly by RN".

67. Care progress notes for later that day record:

[15] A Brylyn Incidents and Accidents Policy was issued and approved in January 2010 and reissued in January 2012 and January 2014.

"Assist for cares with 2 caregivers as she was not holding her weight while doing cares leaning towards her left side."

68. In response to the provisional opinion, NM A stated: "I regret that no pain chart was put in place which was an oversight but anyone, including [RN B], could have started this documentation. Also one could debate the relevance of a pain chart for a person with dementia."

Assessment by GP

69. On the morning of Friday 27 January 2012, Dr F reviewed Mrs C at Brylyn.[16] Mrs C was in bed.

70. NM A told HDC that usually she takes the GP to the resident's room and will then allow them some privacy. Generally, residents go to another room for an examination, but on this day Dr F went into Mrs C's room to examine her. NM A said that she saw part of the examination, but is not sure whether she was present for the entire consultation.

71. Dr F told HDC that he does not recall whether he was made aware of Mrs C's recent falls or inability to weight bear. Her breathing was slower than usual and she was drowsy. Dr F examined Mrs C's back and abdomen. When he roused her to listen to her chest, she complained of her chronic back pain. He said that his main concern was that Mrs C appeared over-sedated, and his priority was to address that.

72. NM A initially told HDC that she thought she had told the GP about the fall, but later said that, given Dr F did not recall being told, she accepted that Dr F was not aware of the fall and thus he had no reason to examine Mrs C further. There is no documentation clarifying whether NM A discussed Mrs C's falls or the associated incident forms with Dr F. In response to the provisional opinion, NM A stated that she stands by her previous recollection that she believes she did advise Dr F of the fall.

73. NM A's entry in the progress notes (the time is not recorded) reads: "am [seen by] [Dr F]. Suggest [decrease] oxycontin back to 5mg and oxynorm to be prn. [Ms D] advised re; consult."

74. NM A telephoned Ms D to advise her of the outcome of the consultation — that Mrs C appeared to be more sleepy and nauseated, possibly due to the opiate, and that her medication had been reduced.

75. Dr F completed his electronic clinic notes at 2.48pm and faxed them to Brylyn at 3.08pm.

76. Dr F's entry reads:

[16] The Brylyn Primary Medical Treatment Policy (issued February 2010 and reviewed February 2012 and January 2014) states: "All Drs. visits must be organised by the R/N or Nurse Manager and they must oversee the visit."

> "[Mrs C] was seen in ED on the weekend. She had an exacerbation of the back pain. They increased the opiate but I am not sure it has helped. She seems more sleepy and nauseated which may be due to opiate. [On examination] [abdomen] soft. tender back and chest clear … Reduce back to our previous oxycontin dose. More [oxynorm] prn Maxolon[17] prn."

Handover between the Nurse Manager and registered nurse

77. NM A told HDC that she and the registered nurse do not see each other in person unless she goes in to Brylyn over a weekend. NM A advised that handover between the NM and RN is not formalised and there is no Brylyn policy governing handover.

78. In response to my provisional opinion, NM A stated:

> "[A]s there was no direct handover between the week day and weekend registered nurses, information was documented in an RN Communication Book and staff Communication Book. The information recorded in [the RN communication] book was mainly general issues about the rest home and staff matters. It rarely contained information about residents and was never considered to be a formal handover of residents. To access more detailed information, the registered nurse was expected to refer to the patient notes, incident forms and previous handover notes."

Handover of resident care information between shifts

79. NM A said that RN B knows all the residents very well, having been employed at Brylyn for a long time. NM A stated that there is good verbal communication between most staff. If there are any changes of note to residents they are written in the staff communication book. In some cases, she may leave additional lists where appropriate. In her absence, some of the Nurse Manager duties are transferred to the RN. These would typically be duties of a care nature, but not human resources or quality management tasks.

80. NM A told HDC that she considered the use of the staff communication book and progress notes to communicate with caregivers to be more effective than caregivers viewing short-term care plans, which may not be fully understood. She said that short-term care plans were good for audit purposes, but there was often insufficient time to update care plans. Also, as Brylyn is small and does not have 24-hour registered nurse cover, not all caregiver staff can be overseen all of the time. In response to my provisional opinion, NM A stated, in relation to her comment about audit purposes: "This is a requirement in agreements with the DHB and MOH. This statement is a fact and does not imply that that was all Short Term Care Plans are good for."

81. NM A also stated in response to my provisional opinion:

> "[H]andover of residents between shifts was formalised. There is a handover held between staff at the beginning of every shift. At these formal handovers information in brief detail is recorded on Handover sheets which are a brief record

[17] Anti-nausea medication.

> of changing clinical circumstances of residents.[18] These are to prompt staff as to what to verbally report to the staff commencing the next shift. Copies of these sheets are kept in a file available to staff to refer to … Information about residents is also written in the progress notes for the resident at the end of each shift. The Handover notes are a prompt to alert the oncoming staff to refer to the resident's progress notes for more detail regarding a change in circumstances … Communication in relation to the falls on 24 and 26 January was in the Handover Notes."

82. The handover sheet dated 24 January 2012, as it relates to Mrs C, records in the margin: "[Phone] call from daughter." In the "AM shift" section it states: "Complaining all shift. Slipped to floor. No injuries."

83. The handover sheet dated 26 January 2012, as it relates to Mrs C, records in the "AM shift" section: "[H]ad a fall in the lounge, walking very slow." Written in the margin is: "[I]ncident form written."

84. RN B told HDC that handovers between her and NM A took place via the RN communication book, and that there had been no mention in the book of Mrs C's falls. RN B was aware that NM A had put in place a pain management care plan for Mrs C.

85. RN B later told HDC that she was aware of the handover sheets, but they were for the care staff to use and they contained very little information, were usually filed away, and she did not have access to them. RN B said that she and the Nurse Manager did not communicate using the sheets, and she did not view the handover sheets when she came on duty to cover the Nurse Manager's leave period.

86. However, there are notes on the handover sheets with RN B's name next to them, which contain instructions to care staff. These include entries on 2 February 2012, 1 February 2012, 30 January 2012, 29 January 2012, and 28 February 2012.

87. RN B's response to HDC included the conclusion that "if [she] had been told or informed that [Mrs C] had had a fall, [she] certainly would have sent [Mrs C] back to [hospital] on that Saturday 28th January 2012."

88. NM A went on annual leave from Saturday 28 January 2012 until Sunday 6 February 2012 inclusive. RN B covered the Nurse Manager position during this period, but she maintained her hours of 7am until about 1–1.30pm, including during weekdays. RN B stated that, in NM A's absence, her hours were not increased, and yet she was still expected to perform her duties plus the running of the home, staffing and residents in her five and a half hours' allotted time. RN B felt that she did not have sufficient time to perform both registered nurse and Nurse Manager duties during the period when NM A was on leave.

[18] Over the course of the investigation, handover sheets had not been mentioned previously or provided in response to HDC's requests for information relating to Mrs C's care. Copies of such sheets relating to Mrs C were subsequently provided to HDC by the new Nurse Manager.

89. In response to the provisional opinion, RN B stated that miscommunications in this case would not have happened if Ms D had told her about her mother's falls, if NM A had given her a handover and left the incident forms out for her attention before going on holiday, and if caregivers had informed her of the incident reports.

90. Prior to going on leave, NM A did not communicate to RN B via the RN communication book, in person, or over the telephone, that Mrs C had fallen on 24 and 26 January. However, information about the falls was present in Mrs C's progress notes and in the handover sheets.

Saturday 28 January 2012

91. On 28 January, RN B recorded in the progress notes that when Mrs C complained of severe pain at 9am, OxyContin and Panadol were given. Mrs C complained of nausea at about 10am and was given Maxolon for relief. RN B recorded in the progress notes: "Buttock area — spine reddened [therefore] duoderm applied to both areas." Both of Mrs C's daughters visited her around lunchtime. Ms D told HDC that she was concerned at her mother's condition.

92. A Wound Assessment and Care Plan was put in place. Mrs C's wound was described as a "burn area on back [right] side" and a "reddened sacral area — duoderm". The template form does not require the person completing it to do more than describe it, so there is no indication of the size of the wound. The plan does not describe or indicate the size or grade of the wound area. The section headed "wound care details/plan" is blank. The plan includes a wound care progress table and entries for five consecutive days.

93. RN B documented in the Wound Care Assessment Plan that she reviewed and treated Mrs C's wound daily between 29 January and 2 February 2012, on one occasion calling the hospital for advice.

94. On 28 January, caregiver Ms I recorded in the progress notes that at 6.30pm while preparing Mrs C for bed, three small blisters were discovered on her back, with some redness. Ms I recorded that Mrs C may have been lying on a wheat bag from the previous morning shift. Ms I also completed an incident form, noting in this and the progress notes that "burn" cream was applied at around 6.30pm, and Mrs C was placed in the recovery position with a pillow for sleeping. RN B, who was on call at that time, was not consulted.

95. RN B told HDC: "Staff were informed via our staff communication book to be extremely careful [with] residents having wheat bags due to burns to their fragile skin, and high doses of pain relief."

Sunday 29 January

96. At 9am RN B actioned Ms I's incident form from the previous day. Mrs C's daughters were advised, and silver sulfadiazine cream (1%)[19] was written up on the incident

[19] An antimicrobial cream used for the prevention and treatment of infection in burns, pressure sores and ulcers.

form to be used on the affected area twice daily. RN B's entry in the progress notes that morning also states that Mrs C was to have silver sulfadiazine cream twice daily. (The wound care plan does not refer to the frequency of use of silver sulfadiazine.) Pain relief was given. RN B noted that Mrs C was "unable to stand on her feet for long [therefore] wheelchair used for safety issues".

97. RN B also wrote in the staff communication book: "[W]hen giving out [wheat bags] to residents please wrap them in a towel to prevent any burning of the resident."

31 January 2012

98. On 31 January 2012, RN B recorded in the progress notes that Mrs C was not walking. Carers recorded that Mrs C required their help to transfer from chair to toilet. Members of Mrs C's family requested a physiotherapy assessment to help improve Mrs C's mobility.

99. Ms D called a mobile physiotherapist, Ms E, and an assessment was scheduled for 2 February 2012.

1 February 2012

100. On Wednesday 1 February 2012, Mrs C was reviewed by RN B. RN B noticed new bruising around Mrs C's left inner upper thigh. Mrs C's left leg was "dragging" but she was able to raise her right leg.

101. RN B recorded in the progress notes:

> "Refusing to walk, but able to lift [right] leg requires 2 persons [with] all cares. Dragging her [left] leg, found bruising on inner upper leg this duty [therefore] incident form written out [and] actioned. Dressing to back. Noted colour discolouration on sacral area [therefore] duoderm reapplied [and] to sit on air ring for comfort. If able, to try [Mrs C] on her side [at] night to settle to prevent any further deterioration to her sacral area (skin) …"

102. The incident form recorded: "Noticed [at 9am] when doing dressing on [Mrs C's] back — Bruising [left] thigh [at] the back. ? cause." No follow-up action is recorded on the form by RN B.

103. RN B wrote in the staff communication book that Mrs C should be sitting up at a 90 degree angle and must not slip down, as the skin around her "sacral area will break open". RN B also wrote in the progress notes that Mrs C required two people for all cares, and requested that Mrs C's position be changed at least 2–3 times a day. RN B noted in the communication book that staff should be careful transferring Mrs C as her skin was very fragile and sensitive. The physiotherapy appointment for 9am the next day was noted. Ms D was not notified of the bruising.

104. It is not documented how RN B determined that Mrs C's left leg was dragging. Dr F's advice was not sought regarding the bruising and dragging, and RN B did not contact the hospital.

105. RN B told HDC that she asked for Mrs C not to weight bear because she "was on so much morphine", and said that she thought the bruising

> "may have been caused when staff had been transferring her from bed to chair to bed etc. When I noticed her left leg dragging, [Mrs C] was sitting in a wheelchair so I naturally thought it may be a pinched nerve from her spine (associated with her severe osteoarthritis) and causing that left foot to be limp."

Assessment by physiotherapist

106. On Thursday 2 February 2012, the visiting physiotherapist, Ms E, assessed Mrs C at Brylyn. Ms E had been asked by Ms D to assess her mother owing to a three-week history of back pain and reduced mobility. Ms E assisted Mrs C to transfer on to a bed from a chair, as Mrs C was unable to weight bear through her left leg because of pain.

107. Upon lying Mrs C on her back, Ms E observed that Mrs C's left leg was laterally rotated and shortened. Ms E also noted that Mrs C had an area of recent onset blue bruising on the left medial thigh/groin area. Ms E thought it likely that Mrs C had a recent hip fracture. She documented:

> "History of decreasing mobility after onset of low back pain 21/1/12. [On examination] [left] leg laterally rotated, shortened, very tender on palpation over hip joint and bruising medial thigh."

108. Ms E discussed her findings with RN B. An ambulance was called and, at 9.50am, Mrs C was referred to hospital for X-ray and review. Mrs C's family was notified. When Ms E informed Dr F of Mrs C's admission, Dr F also attended ED, where he met with Mrs C and Ms D and apologised for any part he might have played in the delayed diagnosis of the fracture. RN B summarised the events surrounding Mrs C's transfer to hospital in the RN communication book for NM A.

Diagnosis

109. The hospital diagnosed Mrs C with a displaced intertrochanteric fracture[20] of the left neck of femur and treated her for this. On the evening of 2 February 2012, nursing staff at the hospital recorded that Mrs C's pressure area wound was severe. Mrs C spent three weeks in hospital. She was eventually discharged to hospital-level care at another facility.

Subsequent events

110. NM A advised HDC that, following Mrs C's care at Brylyn, the following actions took place:

- On 7 February 2012, upon returning from leave, NM A telephoned Ms D to express her concerns and apologise for the delay in diagnosis of Mrs C's fracture. Ms D met with NM A and Ms E that day. NM A told Ms D that this incident would be used as an opportunity to further improve systems at Brylyn. Ms D

[20] Intertrochanteric refers to the proximal, upper part of the femur or thigh bone.

advised HDC that she was unhappy with the meeting and, as a direct consequence, she complained to HDC.

- A staff in-service session was held on pain management, with Mrs C's care used as a case study.
- Brylyn acknowledged that some flaws in its communication took place. Since this event, copies of any incidents that have occurred since the registered nurse's last shift and the GP's last clinic are highlighted separately and left in a folder for all staff to view and access at the beginning of their shift.
- Mrs C's file was volunteered to auditors during a certification audit on 22 February 2012. The events in this case were reviewed using tracer methodology by an auditor/registered nurse.[21] Brylyn gained a three-year DHB certification after the audit process.
- NM A attended a forum on 8 May 2012 at the DHB on Managing Falls and Fractures in the Older Adult.
- A specific policy was developed in relation to heat pack use to ensure that all Brylyn staff wrap wheat bags in a towel.
- Brylyn obtained membership of the New Zealand Aged Care Association.
- Brylyn participated in the DHB's "Enhancing Quality in Residential Aged Care Project" and its associated benchmarking activities.
- Brylyn formed a Health and Safety Committee and undertook an ACC workplace safety management practice audit.

111. In addition, during the course of this investigation:

- Prasad Family Foundation Limited, NM A, and RN B all provided HDC with formal written apologies to Ms D, which were forwarded to her.
- RN B told HDC that she is now more proactive and does not hesitate to send residents back to hospital if there is no improvement, and she acts on her "gut feeling".
- RN B told HDC that she now arrives at work half an hour earlier on a Saturday morning to read all incident and accident forms.
- Brylyn advised that short-term care plans are now to be kept at the front of residents' files so that all staff can access and reference them alongside the communication book and progress notes.
- Brylyn advised that the weekend registered nurse and three caregivers are now on duty during the weekend morning shift.

112. RN B retired from nursing in early December 2013, and advised HDC that she would not be renewing her annual practising certificate with the Nursing Council of New Zealand.

[21] A summary copy was provided to HDC. Tracer methodology is an evaluation method in which surveyors select a patient, resident or client and use that individual's record as a roadmap to move through an organisation to assess and evaluate the organisation's compliance with selected standards, and the organisation's systems of providing care and services.

113. NM A advised HDC in January 2014 that she had resigned from her position as Nurse Manager at Brylyn.

114. In response to the provisional report, Prasad Family Foundation Limited advised HDC that it had no further comments to make.

Relevant standards

115. The Nursing Council of New Zealand Competencies for Registered Nurses[22] include:

> "Competency 1.1
> Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.
> ...
> Competency 1.3
> Demonstrates accountability for directing, monitoring and evaluating the nursing care that is provided by nurse assistants, enrolled nurses and others.
> …
> Competency 2.1
> Provides planned nursing care to achieve identified outcomes.
> …
> Competency 2.2
> Undertakes a comprehensive and accurate nursing assessment of clients in a variety of settings.
> …
> Competency 2.6
> Evaluates health consumer's progress toward expected outcomes in partnership with health consumers.
> …
> Competency 4.1
> Collaborates and participates with colleagues and members of the heath care team to facilitate and co-ordinate care."

Transcribing

116. Transcribing is not specifically defined in legislation or standards. The New Zealand Nurses Organisation (NZNO) has stated that transcribing can include "[w]riting out a

[22] Nursing Council of New Zealand, *Competencies for registered nurses*. NCNZ (Wellington) 2007, reprinted 2012.

patient's current medication on to a Medication Administration Record Chart that is used as an audit record of medicines that have been administered".[23]

117. The NZNO does not recommend transcribing because of the risk of errors, and the risk of reliance on secondary sources rather than the original medication order form.

Sector standards

118. Standards New Zealand Health and Disability Service Standard NZS8134.1.3:2008 includes:

- Medicine Management Standard 3.12:

  "Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

  Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

  3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines …"

- Quality and Risk Management Systems Standard 3.8:

  "Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

  Criteria to achieve this outcome include the organisation ensuring evaluations are conducted at a frequency that enables regular monitoring of progress towards achievement of desired outcomes."

- Service Management Standard 2.2:

  "The organisation ensures 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."

Opinion: Preliminary comments

119. While a resident at Brylyn, Mrs C had a right to care of an appropriate standard. Mrs C was a complex-needs elderly resident with progressive dementia and osteoporosis, and was experiencing ongoing and worsening back pain. In my view, she did not receive the standard of care to which she was entitled.

[23] New Zealand Nurses Organisation, *Guidelines for nurses on the administration of medicines*. NZNO (Wellington) 2012.

120. I am aware that, clinically, it is difficult to determine accurately exactly when Mrs C's fracture occurred, and I do not make any determination on the issue. Regardless, it is evident from the information gathered that, in the lead-up to the physiotherapist's consideration of a diagnosis of hip fracture on 2 February 2012, a series of shortcomings in care and communication occurred, which culminated in care that, when viewed as a whole, was substandard. There were a number of individual departures from standards, as well as organisational deficiencies.

Opinion: NM A — Breach

121. NM A was on duty weekdays until about 4pm, and shared on-call duties with RN B. In addition to her individual professional responsibilities as a registered nurse, NM A's responsibilities included, as outlined in her job description, "maintaining an effective and efficient nursing care delivery system that reflected patient needs and that achieved desired outcomes".

Use of short-term care plans

122. On Sunday 15 January 2012, it was recorded in the progress notes that Mrs C had a reddened area on her back where a wheat bag had been placed. A caregiver had filled in an Incident Report form.

123. NM A reviewed Mrs C on 16 January 2012. NM A considered that the reddened area on Mrs C's back, highlighted by the incident report of the previous day, was pressure related. No short-term care plan for pressure management was instigated in relation to this incident.

124. On 18 January, NM A contacted GP Dr G by fax regarding Mrs C's temperature, ongoing back pain and episode of incontinence. I accept the advice of my nursing expert, Ms Julia Russell, that a reasonable assumption was made that Mrs C could have had a UTI. However, I am concerned about NM A's response to the suspected UTI. In particular, no short-term care plan was instigated when the UTI was suspected; attempts were made but a urine sample was not obtained until 20 January, following commencement of antibiotics; and there were few documented instructions given for staff to follow in relation to why Mrs C's urine should be checked, and the management of her constipation.

125. NM A considered that using the staff communication book and progress notes to communicate with caregivers was more effective than short-term care plans, which she felt might not be fully understood. She considered that short-term care plans were "good for audit purposes" and that there was often insufficient time to update care plans. In response to my provisional opinion, NM A stated: "This is a requirement in agreements with the DHB and MOH. This statement is a fact and does not imply that that was all Short Term Care Plans are good for."

126. Ms Russell advised that "there are some areas of documentation that could be improved such as a pain chart and increased use of short-term care plans to improve documentation and gathering information for sharing with the family".

127. I accept and agree with Ms Russell's advice that short-term care plans are of benefit in ensuring that an RN has made provision for all the care a resident requires. Ms Russell advised that it is evident that short-term care plans were in use for things such as pain management, as seen in the care plan written by NM A on 29 January, but not for other things such as decreased mobility and UTI.

128. In order to provide good care in a rest home environment, residents' care plans must be well documented. A care plan is a fundamental tool that helps enable all staff to provide care that is appropriate and consistent with a resident's changing needs. It is the responsibility of registered nurses to complete and update care plans to ensure continuity of appropriate care. The use of care plans was especially important for Mrs C. Although she had the ability to make some of her own decisions, Mrs C's progressive dementia and documented memory loss potentially affected her ability to communicate signs and symptoms. As Ms Russell has advised, this "is of course one of the reasons for using more specific tools such as specific action plans — short term care plans specifically designed for residents who have this condition".

129. I acknowledge that, as Brylyn provides rest-home level care, much of the day-to-day care is primarily provided by caregiver staff. However, one of NM A's principal working relationships was with a fellow registered nurse. It is also part of the registered nurse role to oversee enrolled nurses and caregivers.[24] I agree with Ms Russell that documentation and instructions to other staff, including care planning, need to be very clear, reflect residents' needs, and be updated for effectiveness. This did not happen in relation to Mrs C to the level of clarity expected given her reduced mobility and other symptoms such as back pain and the episode of incontinence. I am of the view that the lack of adequate care planning also meant that appropriately skilled assessments of treatment efficacy were not being carried out consistently. Therefore, I consider that Mrs C's care in this respect was not adequate.

Care in response to falls on 24 January and 26 January

130. Mrs C slipped to the floor while walking with her mobility frame on 24 January. As Dr F was due to visit on 27 January, follow-up was scheduled for that date.

131. When Mrs C fell again on 26 January, NM A assessed Mrs C, advised Mrs C's daughter, and documented measures to be put in place. Although NM A instigated a combined short-term and pain management care plan after Mrs C's second fall, I agree with my expert adviser, Ms Russell, that the creation of a pain chart with the Pain Management Plan would have been appropriate to ascertain and monitor the scale of Mrs C's pain in her particular personal circumstances, which included her having progressive dementia. I accept Ms Russell's advice that the mobility aspect of the combined care plan should have been reviewed the following day, and a request to

[24] As outlined in nursing competency 1.3.

review daily rather than weekly given. I consider this aspect of Mrs C's care to have been suboptimal.

Interaction with GP Dr F

132. Dr F reviewed Mrs C on the morning of Friday 27 January. Brylyn policy required all incident/accident forms to be shown to the doctor on his visits. Dr F does not recall being advised of Mrs C's falls or inability to weight bear, and so his consultation focussed on Mrs C's level of sedation. Dr F had been sent a copy of Mrs C's discharge summary from the hospital on 21 January, which indicated that Mrs C's medication should be reviewed. NM A initially told HDC that she thought she had told the GP about the fall, but later said that, given Dr F did not recall being told, she accepted that Dr F was not aware of the fall and thus he had no reason to examine Mrs C further. There is no documentation to support that NM A discussed Mrs C's falls or the associated incident forms with Dr F. In response to the provisional opinion, NM A stated that she stands by her previous recollection that she believes she did advise Dr F of the fall. In the circumstances, I remain of the opinion that it is more likely than not that NM A did not advise Dr F of Mrs C's falls.

133. Given Brylyn's policy and Mrs C's likely inability to communicate clearly owing to her dementia, I would have expected NM A to oversee Dr F's entire visit and to bring information about Mrs C's falls to Dr F's attention during his visit, in keeping with Brylyn's Incidents and Accidents Policy. I consider that her failure to do so amounts to inadequate care.

Handover communication

134. NM A and RN B did not see each other in person unless NM A was present at Brylyn over a weekend. Handover between the Nurse Manager and registered nurse roles (which can include some non-clinical matters) was not formalised or governed by a policy, and was usually done via the RN communication book.

135. In relation to the handover communication of residents' clinical care information, I accept that handover sheets and progress notes contained some information about Mrs C's falls, and that RN B clearly had a responsibility to review and familiarise herself with that information prior to going on duty.[25]

136. However, when NM A went on leave (from Saturday 28 January to Monday 7 February), RN B had not been on duty since the previous weekend. Prior to going on leave, NM A did not communicate to RN B via the RN communication book, in person, or over the telephone, that Mrs C had fallen on 24 and 26 January.

137. I remain of the view that there was an onus on NM A, as the senior staff member and Nurse Manager, to ensure that she updated RN B with residents' clinical care details from the week elapsed, prior to going on leave.

138. After Mrs C's second fall, the progress notes show that her mobility and ability to weight bear reduced, but no action was taken in response to this. Ms Russell advised

[25] See pages 22-24.

that the inaction regarding reviewing Mrs C's mobility occurred as a culmination of a number of issues, including:

> "[a] series of poor communications related to history of the communication by two staff who don't work together. Historically this has been relatively informal however, as the care of Residents increases this needs to increase and be more formal so that full communication occurs."

139. The degree and nature of this communication, in tandem with NM A's infrequent use of care plans, was, in my view, ineffective and insufficient to provide appropriate continuity of care between NM A and RN B.

Conclusion

140. NM A did not utilise short-term care plans for pressure management of Mrs C's spine or her suspected UTI on 16 January 2012. No pain chart was used in conjunction with the pain management plan formulated after Mrs C's second fall on 26 January. Limited guidance was given to staff regarding Mrs C's reduced mobility, the reasons to check her urine, and the management of constipation. In my opinion, the lack of adequate care planning also meant that appropriately skilled assessments of treatment efficacy were not being carried out consistently. I remain of the opinion that NM A did not provide services to Mrs C with reasonable care and skill. Accordingly, she breached Right 4(1) of the Code.

141. I find that NM A did not advise Dr F about Mrs C's falls. I remain of the opinion that, in addition, the informal and indirect nature of handover communications between NM A and RN B, in tandem with NM A's infrequent use of short-term care plans, meant that important information about changing clinical circumstances was not adequately provided to RN B, and this contributed to a lack of continuity in Mrs C's care. Accordingly, I find that NM A breached Right 4(5) of the Code.

Opinion: RN B — Breach

142. RN B is an experienced registered nurse who was familiar with the Brylyn residents and was on duty at weekends between 7am and approximately 1–1.30pm. When NM A went on leave, RN B covered the NM position during the week, but maintained the same hours of 7am to 1–1.30pm. Brylyn job description documents state that its registered nurses have overall responsibility and accountability for all medical practices occurring at Brylyn.

Lack of file review — Breach

143. Although there was no formal facility policy to govern handover from NM A to RN B prior to NM A going on leave, and NM A had not communicated information about Mrs C's falls in the RN communication book, this does not, in my view, excuse the fact that RN B did not review or familiarise herself with Mrs C's clinical condition and care, including the handover sheets, progress notes and incident reports, prior to

starting the period of cover for NM A's leave on Saturday 28 January 2012. Had RN B done so, she would have been aware of the two falls, and she may have identified Mrs C's pattern of deterioration and ongoing pain, and been in a more informed position to assess the symptoms Mrs C exhibited on 1 February.

144. I note that RN B told HDC that she did not have access to the handover sheets. However, there are notes with her name next to them on the handover sheets. RN B also said that she was aware of the handover sheets but did not review them prior to going on duty on 28 January.

145. I remain of the opinion that RN B's failure to familiarise herself with Mrs C's clinical condition and care was inadequate.

Wound assessment and care — Breach

146. A reddened area on Mrs C's spine was first identified on 15 January 2012. RN B applied a Duoderm dressing on 21 January but did not start a short-term care plan. On 28 January RN B put in place a wound assessment plan, but it did not indicate the size or describe the grade of the wound. The instructions on the wound plan stated that the wound required daily review, but did not make any reference to how often to use the silver sulfadiazine cream. The progress notes and the incident form completed on 28 January state that silver sulfadiazine cream should be applied twice daily. Ms Russell advised that RN B did not differentiate between the care required for the bruises and the pressure area. Ms Russell also advised: "The actions taken here were appropriate however the documentation, description of the wound let this process down and as such there is a moderate departure from the standards and expectations of reasonable care."

147. I accept my expert's advice. I also note her comment that "[a] thorough short term care plan or adjustment to the long term care plan would have brought all the information from the wound chart and the daily notes together", and that improvement could be made by including a wound management chart that identifies the grade for each area.

1 February assessment of leg — Breach

148. RN B's assessment of Mrs C's new bruising and left leg "dragging" did not include consideration of a fracture as the cause of Mrs C's pain. Based on her notes, RN B's assessment was primarily related to the wound on Mrs C's spine, although the condition of Mrs C's legs was clearly identified. RN B did not advise Mrs C's family of the bruising noted and that a cause could not be identified, and did not seek any advice from either the GP or the hospital.

149. Ms Russell noted that Mrs C's overall picture was deteriorating over the week before 1 February. I am concerned that RN B did not seek clinical advice or assistance in response to Mrs C's bruising and dragging of her leg on 1 February and, in my view, her failure to do so was inadequate care. As my expert advised:

> "Having read [RN B's] response she identifies she wasn't aware of the further falls. Which is no doubt due to not looking through the files and getting herself up

> to date … [F]ollowing the earlier x ray and on-going deterioration I do wonder why the Dr wasn't called … The actions taken here were not appropriate and do not meet the expectations of reasonable care."

Conclusions

150. RN B failed to review and familiarise herself appropriately with Mrs C's clinical condition and care when commencing her duties on 28 January 2012. RN B's assessment, evaluation and response to Mrs C's symptoms of bruising and dragging of her leg on 1 February 2012 were not adequate. In my view, RN B failed to provide services to Mrs C with reasonable care and skill and therefore breached Right 4(1) of the Code.

151. RN B did not complete an accurate wound description, wound chart and short-term wound care plan. In my opinion, these actions did not comply with professional nursing standards and, accordingly, RN B breached Right 4(2) of the Code.

Other comment — Transcribing

152. When RN B was called back to Brylyn at around 2.15pm on Saturday 21 January 2012 to review Mrs C, she made a collaborative decision with Mrs C's family members to have Mrs C transferred to hospital because of her level of pain. The ensuing hospital assessment resulted in the registrar completing and signing a prescription for OxyNorm and OxyContin, and three days of diazepam.

153. RN B later transcribed the hospital prescriptions (including opiates) on to Brylyn medication administration charts. I am aware that the practice of transcribing prescribed medicines is not recommended by the nursing profession. This is because of the obvious potential for administration errors to occur if a secondary source (a rest home administration chart, for example) is relied on and this inadvertently contains a transcribing error. I recognise that where a resident returns from hospital with newly prescribed medicine, it is not practical to have the prescribing practitioner enter the medication on the medicines administration record. In this case, a copy of the primary source of the prescribed medication (the ED registrar's prescription and the discharge summary) was on file alongside the rest home medicines administration record.

Opinion: Prasad Family Foundation Limited — Breach

154. While I have identified my concerns about the decision-making and actions of individual staff, Prasad Family Foundation Ltd also had a responsibility, in line with the New Zealand Health and Disability Sector Standards (see above), to operate Brylyn in a manner that provided residents with timely, appropriate, and safe care.[26]

155. As discussed, I am concerned that there was no formalised policy in place to govern handover and effective communication between the roles of the Nurse Manager and

[26] See Opinion 11HDC00940 (28 November 2013).

registered nurse. Although communication with Mrs C's family was generally timely, poor communication between staff was a characteristic of these events.

156. While I appreciate that Brylyn is a small facility and residents were well known to staff, this case highlights that the use of progress notes and handover sheets as evaluation tools was not sufficient, particularly in the absence of regular short-term care plans. Important clinical information (particularly regarding Mrs C's falls) was not passed on effectively, and a lack of continuity of care ensued.

157. As Ms Russell emphasised in relation to the role of care plans in the context of communication:

> "Nursing plans are more than just a set of interventions — there needs to be identified outcomes to meet the identified needs. They are of use in ensuring that all the areas have been considered by the RN in planning care and this should be conveyed to Care Staff and RNs at handovers in communication books by referring to the use of short term care plans. The use of short-term care plans should involve family and this improves the professional appearance and gives Staff, Residents and Families confidence that all areas of care required have been considered and planned for. Utilising short-term care plans is directly related to the Certification Standards; service provision — 1.3.8 …"

158. As this Office has emphasised previously, rest-home owners have an organisational duty of care to provide a safe healthcare environment for their residents.[27] This duty of care includes ensuring that staff work together and communicate effectively, ensuring that policies and procedures are consistent with relevant standards, and ensuring that staff comply with the policies and procedures.[28] The systems within which a team operates must function effectively in order to provide an appropriate standard of care to residents. In my view, in this case the system in place for communication between staff was not effective.

159. I am also mindful of RN B's comment that she felt she did not have sufficient time to perform both registered nurse and Nurse Manager duties during the period when NM A was on leave. Ms Russell advised:

> "At the time of this situation [RN B] work[ed] a short shift over the weekend, and when she relieved the Nurse Manager she worked the same short day, finishing after the 1pm medication round. Whilst I appreciate she doesn't do the same job as the nurse manager the staff, families and residents are used to having someone there till after 4pm to attend to things. I think it is reasonable for relief staff to work on site — not just to be available on call in a relief role."

160. I share Ms Russell's concern about the level of staffing and support available for RN B during that 10-day period, the lack of a weekday, on-site RN between 1.30pm and 4pm over this period, and the contribution of these factors to the level of care

[27] Opinion 11HDC00423 (27 June 2013).
[28] Opinion 08HDC17309 (26 May 2010).

provided to residents. In addition, I note that when Ms I applied what she described as "burn cream" to Mrs C around 6.30pm on the evening of 28 January, RN B was not on duty but was on call. RN B was not consulted about use of the cream. The wound plan relating to this was not developed until RN B returned to duty the following day. Ms Russell advised that "it appears from the notes that the assessment for this burn and the application of the cream appears to have been done by a care staff member. This is not acceptable." I agree that this was not appropriate in the circumstances.

161. In relation to Brylyn's wound chart template form, I note Ms Russell's advice that "[t]he Brylyn rest home wound chart does not require the person completing it to do more than describe it so there is no indication of size of the area etc on this". In my view, a more detailed wound plan template form with such information would have provided more detail about the wound to other staff and providers who subsequently cared for Mrs C.

Conclusion

162. In light of the above deficiencies, I consider that, at the time of the events complained of, Prasad Family Foundation Ltd did not take sufficient steps to ensure that appropriate systems, policies and guidelines were in place to provide services to Mrs C with reasonable care and skill. Therefore, in my view, it breached Right 4(1) of the Code.

163. Brylyn has acknowledged that deficiencies occurred in Mrs C's care. I accept that in relation to the subsequent changes made by Brylyn to address the issues highlighted by Mrs C's case, this matter has been taken seriously and steps have been taken to improve the overall standard of care provided.

Recommendations

164. I recommend that within two months of issue of this report, Brylyn conduct a review of its systems, and:

- Provide HDC with a copy of the staff in-service session on pain management held as a result of Mrs C's case.
- Provide feedback on the effectiveness of staff having access to incident reports when they are on duty.
- Provide a copy of the policy developed in relation to heat pack use.
- Provide an update on the effectiveness of short-term care plans being kept at the front of residents' files so that all staff can access and reference them alongside the staff communication book and progress notes.
- Provide an update on the effect of the weekend staffing changes made as a result of Mrs C's care.

165. I also recommend that, in conjunction with its funders, Brylyn develop and provide HDC with a clear and comprehensive set of its updated and co-ordinated policies and procedures, which should include:

1. A medicine management policy.
2. An admission policy that provides a guideline for staff on understanding and discussing EPOA status with residents and their families.
3. A policy governing effective formal clinical handover from the Nurse Manager to the registered nurse.
4. A policy on the incorporation of appropriate short-term care plans, pain management charts, and wound care charts in ongoing monitoring of resident care.

166. I recommend that NM A review her nursing practice in light of this report and, within three months of issue of this report, provide evidence of having completed professional refresher education in the area of care planning, monitoring and evaluation of treatment efficacy in aged care.

167. I have recommended to the Nursing Council of New Zealand that, in the event that RN B applies to renew her annual practising certificate for any reason (such as performing locum duties), she first review her practice in conjunction with the Council.

Follow-up actions

168.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Prasad Family Foundation Ltd (trading as Brylyn Residential Care), will be sent to the Nursing Council of New Zealand, and it will be advised of the names of NM A and RN B.

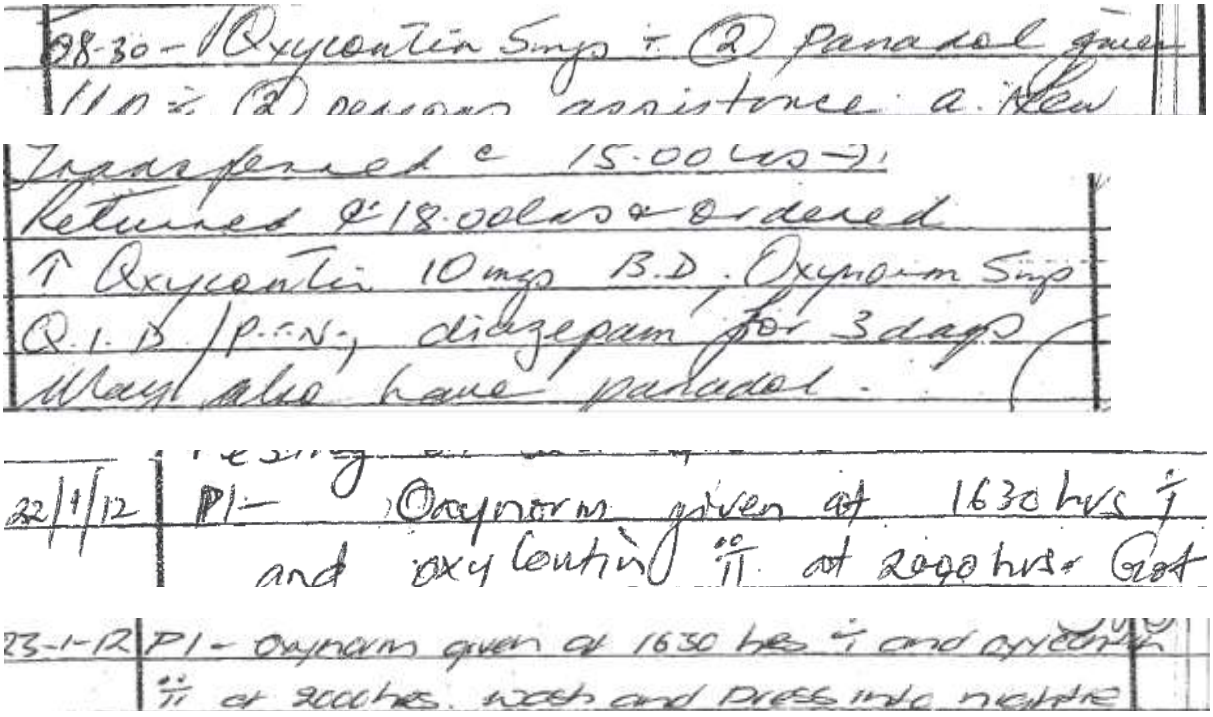
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Prasad Family Foundation Ltd (trading as Brylyn Residential Care), will be sent to the DHB and HealthCERT (Ministry of Health).

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Prasad Family Foundation Ltd (trading as Brylyn Residential Care) will be sent to the College of Nurses Aotearoa Inc, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice

The following expert advice was obtained from Ms Julia Russell:

> "Thank you for the opportunity to further review [Mrs C's] file with regard to the standard of care provided to her by Brylyn Resthome. The initial report was written on the 18 March 2013. The advice provided in the initial report was identified as a severe departure. This was based on the associated documentation and actions that were identified as inconsistent with Brylyn's normal practice. These included not notifying the family about the extra bruising found on the 1/2/12, not requesting a further assessment by the GP despite noting [Mrs C's] deterioration.[29]
>
> Upon reviewing my initial report it is evident that the person I identified as transcribing is [RN B] not [NM A]. [RN B] reports to [NM A] and [RN B] would be reading the daily notes so should be aware that this practise existed — it also does amongst the care staff. Please see the examples I was referring to below. I would expect that this matter has been raised with [RN B] and other staff and this practise has ceased.
>
> Excerpts from [Mrs C's] notes.



[29] Ms Russell's initial advice dated 18 March 2013 was obtained at a preliminary stage prior to Ms Russell's review of all information being gathered. That advice is superseded by this report and, therefore, it is not attached.

This report is specifically to focus on the care provided by [RN B], [NM A] and Brylyn Rest Home and answer the following questions.

1. *The appropriateness of the care [Mrs C] received in response to her back pain and reddened areas on her back in the period 15 January 2012 to 21 January 2012 leading up to her brief hospital admission.*

There is no doubt as it is fully recorded that [Mrs C] was a complex Resident with complex needs which she was not always able to articulate clearly, given her dementia. This inability to communicate is of course one of the reasons for using more specific tools such as specific action plans — short term care plans specifically designed for Residents who have this condition. [Mrs C] had long term issues with back pain and took daily medication for this as well as using a wheat bag. In the earlier notes provided there is infrequent mention of back pain — although it is in the initial long term plan for [Mrs C].

The care provided in the period of 15/1/12 to 21/1/12 is part of the concerns raised by [Ms D] in her complaint and seems to be where [she] became concerned about the care her mother was receiving. On the 9/1/12 [Mrs C] is noted as being demanding in the afternoon but for that week there is no further recording or concern regarding pain noted until the 15/1/12 where it seems to have become a daily reporting including the wheat bag use.

When the wheat bag was applied on the night of the 15/1 there was also an inspection of her back by the care staff member and a reddened area was noted, an incident/accident form was completed. [NM A] followed the incident up and believed it was a pressure issue rather than a burn — this had been noted earlier in her time at Brylyn Resthome. [NM A] also notes about her being uncooperative at this time.

On the 17/1 she didn't eat lunch and was incontinent overnight. A reasonable assumption was made that this could have been a urinary tract infection and antibiotic treatment was undertaken. [NM A] notes on the 19/1 that she looks a little better and that food and fluids need to be encouraged.

The 20/1 is an unremarkable day.

The 21/1 [RN B] notes the antibiotics have finished — that she is walking slowly and a duoderm is placed on her lower back to assist with pressure management. The area is not noted as being broken. On that day she refuses Panadol (asks for something stronger — morphine) after lunch at 2:30pm takes the Panadol. [RN B] has been called back to Brylyn due to [Mrs C's] severe pain — speaks with [Ms D] and the decision is to transfer her to the hospital. [RN B] must have come back to Brylyn after [Mrs C] returned as she records what the new orders for medications are.

2. *The standard of nursing care provided on 21 January 2012 when a decision was made to transfer [Mrs C] to hospital.*

The decision on what X-rays were taken would be as the result of the assessment at the emergency department and Rest homes have little effect on this. A common

practice is to call the emergency department and discuss with the Co-ordinator or similar position what the concerns are such as decreased mobility, varying and non specific pain. If this occurred it is not documented and I do not know if this is a practice in [the area]. Whether such actions would have made any difference cannot be measured.

As noted above [RN B] has been called back to Brylyn at 2:30pm due to [Mrs C's] severe pain — speaks with [Ms D] and the decision is to transfer her to the hospital. [RN B] must have come back to Brylyn after [Mrs C] returned at 6pm as she records what the new orders for medications are.

In her later response to these matters, [RN B] stated when the mobility continued to be poor as [RN B] says she should have followed her gut to more fully review this. The 22/1 was a Sunday and no doubt she thought [Mrs C] may have improved. [RN B] is also not back at work until the following weekend so the care is in [NM A's] hands.

The actions taken here were completely appropriate and meet the expectations of reasonable care.

3. *The standard of care provided in response to [Mrs C's] fall on 24 January 2012.*

On the 22/1 despite this increase in medication [Mrs C] is still complaining of back pain — both her daughters visit that day. These complaints of pain continue on the 23/1 with a staff member raising that [Mrs C] walked well when no one was looking and [NM A] records that she observed her slipping gently to the floor — incident form completed and it was noted she was uncooperative and not holding herself up to walk. Over these few days, her food intake is variable and on the 26/1 she has a further fall with an associated skin tear

In the short term care plan written on the 26/1/12 it says assess where the pain is — given [Mrs C's] varying level of ability and varying responses this request wouldn't be an ideal way to ascertain this, the use of an appropriate pain chart — care staff would require training in the use of this.

The actions taken are a mild departure from the standard expected to meet the expectations of reasonable care.

4. *The standard of care and assessment of [Mrs C] in response to [Mrs C's] fall on 26 January 2012.*

In reviewing the daily notes, it appears that [Mrs C's] mobility did decrease from 26/1 fall. On that evening, it is reported by the care staff that she could not weight bear. This should have been brought to the attention of the on call person, but does not appear to have been.

As [NM A] states on the 26/1 the Doctor was coming the next day so this is the reason that no other actions were taken. The short term care plan regarding mobility — food and fluids etc was done on this day given [Mrs C's] decline overnight — this should have been reviewed the next day and a request to review perhaps daily rather than weekly given.

At the Doctors visit the Doctor doesn't recall being told of a further fall and was more concerned with the level of sedation. It is an assumption that [NM A] was part of that consult between the Dr and [Mrs C] as [Mrs C] would not be able to tell him clearly due to her dementia — but this appears not to have been the case. If it was the case when she realised that the Dr hadn't reviewed her leg could have called him to further discuss. As is a regular practise in many facilities the Dr does his notes back at the surgery and faxes them to the Facility. It appears the notes were faxed to Brylyn at 1508 and it is not clear whether [NM A] saw this before she went on leave. This appears to be the first miscommunication.

I have presumed that [NM A] did not go with the Dr to see [Mrs C] so the information he had regarding falls etc was not clear and given that she would not be a good historian the actions taken here were not appropriate and do not meet the expectations of reasonable care.

5. *The standard of wound care provided on 28 January 2012 in response to [Mrs C's] reddened buttock and spine.*

There are a number of issues here.

- This area appears to have followed on from the reddened area seen on the 15/1 where it was noted this appeared to be more about pressure than a burn. On the 21/1 a duoderm was applied to minimise pressure. The daily notes do not record if this continued and there was no short-term care plan regarding this. There is a note in the communication book on the 30/1 or 1/2 regarding positioning and pressure and actions to be taken for the reddened area.
- The Brylyn Resthome wound chart does not require the person completing it to do more than describe it so there is no indication of size of the area etc on this. [RN B] records the actions required on the incident form as apply the silver sulfadiazine twice daily. The wound chart says daily on the same day. On the 1/2 [RN B] notes that the sacral area has become discoloured and an air ring is placed — presumably to minimise pressure. [RN B] sought advice and removed the air ring. The use and management of silver sulfadiazine cream — it appears from the notes that the assessment for this burn and the application of the cream appears was done by a care staff member. This is not acceptable. A thorough short term care plan or adjustment to the long term care plan would have brought all the information from the wound chart and the daily notes together.
- [RN B] instructs the carers to be careful and aware of the need to manage the wheat bags with care and around the transfer and positioning of [Mrs C]. Areas of improvement would include a more useful wound management chart — that would identify the grade of the area and have a chart for each area — this would be one for the blisters requiring daily attention and one for the pressure area.

  At 10:30pm on 2/2 the nurse caring for [Mrs C] at the hospital describes the pressure area as severe, grading of pressure areas is done on a 1–4 scale. Given that [Mrs C] is now in hospital it is impossible to know how [Mrs C] had been cared for over the day, sometime over that day it is noted that she last ate and

maybe drank at 9am. However, the pressure area would have been affected by what sort of bed/mattress she was on, had she been able to get off the affected areas, the amount of food and fluid she was having. Given the day spent in the hospital, the description of the pressure area by the hospital nurse and the lack of grading by [RN B] I do not believe that Brylyn Resthome can be responsible for the deterioration observed in the wound.

- Management of wheat bags – actions taken to improve the management of this have been taken.

The actions taken here were appropriate however the documentation, description of the wound let this process down and as such there is a moderate departure from the standards and expectations of reasonable care.

6. *The standard of nursing assessment and care of [Mrs C] on 1 February 2012 when bruising and dragging of the left leg was noticed.*

[RN B] notes on 31/1 that [Mrs C] is not walking and that evening the carers note that they are transferring her from chair and toilet and she is not standing. On the 1/2 [RN B] whilst doing [Mrs C's] dressing assesses her and finds bruising in the thigh area, that she is dragging her left leg (which is later identified as being fractured) but can lift her right leg.

This assessment suggests [RN B] is looking at what condition her legs are in. Having read [RN B's] response she identifies she wasn't aware of the further falls. Which is no doubt due to not looking through the files and getting herself up to date — I believe is a result of being a busy job and not having been in this practise it did not occur at this time. However, following the earlier x ray on and on-going deterioration I do wonder why the Dr wasn't called.

A review of [Mrs C's] notes may have alerted her that the Dr had not checked her leg and that this was an on-going issue now for most of the past two weeks. [RN B] knew the Physiotherapist was coming in on the 2/2 and was perhaps relying on this.

The actions taken here were not appropriate and do not meet the expectations of reasonable care.

7. *The standard and appropriateness of handover and communications between Brylyn staff.*

Brylyn is a Residential facility which means that most of the day care and support for Residents is provided by care staff. These staff are described as good staff and communication occurs by the use of handover and the communication book and it is clear from the care staff notes (as also identified by the RNs in their responses) that they follow the requests made of them.

The passing of information amongst the RNs and care staff seems to be appropriate and it is evident that the care staff read the communication book and act on the instructions given there. [NM A's] comments regarding the use of short term care plans were that they are of more benefit for audit purposes. I believe that

they are benefit in ensuring that the RN has made provision for all the care required which in my experience if the RN has not documented it in a planning process does not always occur — as in this case. In this case, the carers were told what to do by way of the communication in book however, if [RN B] had sat and written a plan which would have required a review of the notes she may have been able to identify the gaps that were there. These gaps included the Dr not assessing [Mrs C's] lower limbs as it appears was the expectation of that visit.

In the review of the documentation from Brylyn Resthome it is evident that short term care plans are in use for things such as pain management written by [NM A] on the 29/1/12 but not for other Resident requirements such as — decreased mobility, urinary tract infection. [NM A] is working with [RN B] who needs to clearly understand what the plan of care is. This should be more than a note in a communication book. Nursing plans are more than just a set of interventions — there needs to be identified outcomes to meet the identified needs. They are of use in ensuring that all the areas have been considered by the RN in planning care and this should be conveyed to Care Staff and RNs at handovers in communication books by referring to the use of short term care plans. The use of short-term care plans should involve family and this improves the professional appearance and gives Staff, Residents and Families confidence that all areas of care required have been considered and planned for. Utilising short-term care plans is directly related to the Certification Standards; service provision — 1.3.8 and in 1.1.9 — open disclosure.

The passing of information between two staff who do not work together is less ideal for exactly the reason, these two staff never work together and handover occurs by the occasional phone call and the communication book. Both RNs in their own feedback [RN B] notes that there is not information regarding [Mrs C's] falling on the 26/1. There is a note in the communication book from the 20/1 from [NM A] to [RN B] (hard to know as it is not addressed to [RN B] or signed by [NM A]. Given the increasing complexity of Residents it may be of benefit to have a regular review of matters between these two RNs. Also the use of a handover form which has every Resident's name on it so rather than noting what staff recall they are forced to make a comment on all Residents.

[NM A] refers to there being insufficient time to always update care plans and this of course leads to the situation that has occurred — [RN B] did not always see all the incident forms that had occurred over the previous week. She does now as she arrives early and they are in an area where they are all accessible.

At the time of this situation [RN B] work[ed] a short shift over the weekend, and when she relieved the Nurse Manager she worked the same short day, finishing after the 1pm medication round. Whilst I appreciate she doesn't do the same job as the nurse manager the staff, families and residents are used to having someone there till after 4pm to attend to things. I think it is reasonable for relief staff to work on site — not just to be available on call in a relief role.

This may have enabled a file review to have occurred which may have alerted the RNs to the ongoing deterioration. [RN B] says in her notes that she believes that if she knew about the earlier fall her responses may have been different. This

comment relates to how the communication book is used and the time that [RN B] has to do her work in. This relates to the staffing levels available at the facility and also about how staff deal with complicated matters — taking the time to review the file.

In her letter of complaint, [Ms D] suggests that the staff did not take the behaviour her mother was demonstrating seriously because they thought it was related to her dementia and not a decline in her condition. Two different staff on the 24/1 make a similar comment — the slip fall to the floor and the ability to walk better when [Mrs C] thought there was no one watching. It is impossible to judge this except by the use of the documentation and it does appear from the notes that there is a view that [Mrs C] does seek attention.

The actions taken here were not appropriate and do not meet the expectations of reasonable care.

8. The standard and appropriateness of handover and communications between Brylyn staff and other health care providers.

It appears that Brylyn staff seek advice from external providers and other providers are available for training. Notably there had been training about managing complaints in 2011 by the Health and Disability Commissioner's advocate. It is not known if the staff involved with responding to [Ms D's] initial concerns — the Carer and [NM A] attended this training.

I have commented earlier on the Drs notes arriving at 3:08pm on the last day [NM A] was working so it is impossible to know if she saw those or if [RN B] did the next day or during the week when she was acting nurse manager.

I have also commented on communication opportunities such as talking to the hospital emergency department pre transfer regarding the 21/1 x ray that [RN B] arranged.

In the wound care plan, [RN B] sought advice from the Hospital regarding the air ring and acted upon the advice given.

The actions taken here were not appropriate and do not meet the expectations of reasonable care.

9. The quality of communication with [Mrs C's] family members.

[Ms D] says in her letter that communication was generally good with the staff and comments on her surprise about the way the care staff referred to the pain her mother was experiencing. Both RNs kept the family aware of what was happening around all events; why this did not occur with regard to the bruising on the 1/2 is not answered by [RN B] in her response.

In [NM A's] phone call to [Ms D] on the 9/2 and her further 21/5 phone call to [NM A] was taking the initiative to try and resolve the concerns with [Ms D]. There was not a response to the 21/5 call made by [NM A] because of course [Ms D's] complaint is dated 1/5. It is easy to consider in hindsight if [NM A] had

called a month earlier if [Ms D] would have felt her concerns would had been addressed and this process averted.

In reviewing the notes following [Mrs C's] hospitalisation and transfer [NM A] recorded the various conversations that were held regarding the situation as experienced by the Brylyn RNs and care staff. [NM A] says that this situation will be used as an opportunity for improvement. This is what [Ms D] said in her complaint letter that she wanted to see as a result of this. The actual dates the hours were increased in the weekends are unknown but the policy and procedures changes can be seen from the dates on the documents.

The actions taken here were appropriate and meet the expectations of reasonable care.

10. *The appropriateness of Brylyn staffing levels and cover in the Nurse Manager's absence.*

Roles in Resthomes are busy and the requirements for RN staff are ever increasing. The result of pressure and general busyness on staff when doing relief cover for positions often means that the recording of the care provided does not always occur.

I think the alterations to the weekend staffing to ensure that [RN B] has extra staff working with her will be very helpful and expect that this will enable her to update care plans and do short term care plans as necessary which in turn should be helpful to [NM A].

The expectations are not appropriate in a busy area and have contributed to the Staff not meeting the expectations of reasonable care.

11. *The appropriateness of Brylyn policies and procedures in place at the time of the events.*

They updated their information on wheat bags, fall prevention and have issued an incident/accident policy in October 2012. They have reviewed and increased weekend staffing but it is not clear about staffing when the Nurse Manager is on leave.

The Nurse Manager has attended training about falls which I assume has been shared with all the staff including the weekend RN who I would identify as most in need of training as she works the weekend when there is least support on.

[NM A] developed and implemented a short term care plan in January 2012, and although it is not mentioned has no doubt done training with [RN B] regarding these.

The actions taken here are appropriate and meet the expectations of reasonable care.

12. *The appropriateness of steps taken and remedial actions put in place by Brylyn subsequent to [Ms D's] complaint.*

The actions taken by Brylyn and [NM A] and [RN B] have been appropriate and addressed the areas that required action in respect of policies and procedures:

- Fall prevention practices issues 25/10/12.
- Incidents and Accidents Policy 27/01/12, which includes having a file where all incident/accident forms are reviewed by the doctor on his visits if he was required for an immediate follow up to an issue. I have presumed that the Incidents and Accidents policy was developed and implemented as an area Brylyn saw requiring attention as this policy was signed off the day before [NM A's] 28/1/12 leave. The Falls Prevention Practices policy was issued in October of that year again perhaps as a result of reflection on this situation.
- Membership of the NZACA, this has a useful forum available to practitioners to ask questions and check out various issues.
- Use of the Joanna Briggs institute information to assist with training and development.
- Education of RN staff at local Falls Prevention forum
- There was training occurring at the time as [in] [NM A's] interview notes there are references to an inservice (26/1/12) where pain monitoring was discussed and [Mrs C] was used as an example and a pain management chart was suggested at the inservice but does not appear to have been implemented.
- Staffing — weekend hours when the facility is full have been increased. In [NM A's] interview notes she refers to [RN B] working until 1pm or when things are completed. [RN B] refers to coming in 30 minutes early to review care plans and notes. It is not clear if this is paid time or time that [RN B] gives to Brylyn Resthome and this perhaps needs to be fully clarified. It is understood that a relief role won't undertake all the normal things the position holder does, however the Mon–Fri staff are used to having an RN on site until later than 1pm and also there is no doubt that those people who undertake a position on a relief basis will probably take longer to undertake the responsibilities of the permanent position holder.

The actions taken here are appropriate and meet the expectations of reasonable care.

In conclusion

In further reviewing this file with the extra information that is available the actions that I believe were of the most concern are the inaction regarding reviewing [Mrs C's] mobility. In determining the actual cause of why these actions were not taken I do not believe it is related to the deliberate inaction of any of the staff involved. As was identified in the previous report and the feedback from the Dr and Physiotherapist it is impossible to identify when the fracture actually occurred. I see what has occurred as a culmination of a number of issues that include:

A series of poor communications related to history of the communication by two staff who don't work together. Historically this has been relatively informal however, as the care of Residents increases this needs to increase and be more formal so that full communication occurs. This includes the opportunity for the documentation around this to have been better — which would have included a file review. This would probably have been done by [NM A] in her role however she was on leave — [RN B] was working reduced hours in this role so this did not occur. The tools to complete such a review were not available — pain chart or short term care plans regularly used as the value of them has been questioned by

[NM A] in her response. It is indicated in the feedback that these are now being used. Training on the use of such tools would also need to be available to caring and Registered staff so they are used to best effect.

These miscommunications were related to:

- the impending leave of [NM A] who would have been busy getting the aspects of her job up to date before leaving and didn't see what the Dr wrote. This does not appear to have been seen by [RN B] at any time over the next week either
- pressure on staff doing someone else's role granted [RN B] wouldn't have done all the job elements in shortened hours. I have commented on this earlier.

The communication with [Ms D] by the Carer and [NM A] after [Mrs C] was hospitalised. An offer to do a full review may have minimised the step that [Ms D] took to complain to the Health and Disability Commissioner. The certification audit occurred in late February 2012 and the finding from the auditor could have been shared at this time with [Ms D]. This would have been difficult to do when [Mrs C] was no longer a Brylyn Resident, however, [NM A] showed in her follow-up communications that she was capable and committed to having this resolved.

[RN B] identified needs but has not taken the time and hasn't had the tools to undertake the planning required. If the file review had occurred I think [Mrs C] would have been reviewed earlier. This may have been by a further X-ray or GP review.

The reasons this situation was considered severe was due to the associated actions and communication that I considered as a severe departure from the standards. Given the changes that have resulted in practice of the two RNs involved and more particularly the extra staffing that has been implemented at the weekends and I would assume when the Nurse Manager is on leave to ensure that the relief RN has extra time to get to the ever increasing requirements that are expected in these busy roles.

My final comment in the March 2012 report was related to seeing if the new policies, Fall prevention and Incident and Accidents, implemented at the time or following this situation have made a difference in monitoring, observing and reporting of the Residents of Brylyn. Given the feedback received, I believe this matter has been taken seriously and am sure that these RNs as well as the Facility owners have made the necessary changes.

Are there any other aspects of the standard of care provided that you consider warrant additional comment?

In reference to the positive audit report and tracer methodology at the time of the Brylyn Resthome 22/2/12 audit. The auditor had the benefit of talking to the staff involved at Brylyn but did not have the benefit of talking to [Ms D] or reading [Ms D's] letter regarding her experience of this as of course [Mrs C] had since moved to another home by the time of the audit.

Julia Russell, MN, RN"