Registered Nurse, Ms C

Birkenhead Lodge Retirement Home

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC10236)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

This report considers the appropriateness of the care provided to an elderly woman while she was a resident at Birkenhead Lodge Retirement Home from 30 August 2006 until her admission to a public hospital on 10 June 2008 with severe pressure sores. The report also considers the appropriateness of financial charges applied by Birkenhead Lodge Retirement Home.

Complaint and investigation

On 16 June 2008 the Commissioner (HDC) received a complaint from a District Health Board about the services provided to Mrs A by Birkenhead Lodge Retirement Home. Mrs A's son, Mr B, subsequently complained to HDC. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by Birkenhead Lodge Retirement Home.*

- *The appropriateness of the care provided to Mrs A by manager Ms C.*

The investigation was delegated to Deputy Commissioner Rae Lamb.

Information was obtained from:

Mr B	Complainant/ consumer's son
Ms C	Provider/ manager and registered nurse
Ms D	Registered nurse
Dr E	General practitioner
Ms F	Specialist wound care nurse
Ms H	Podiatrist
Podiatrist team	Podiatrists
Ms I	Registered nurse
Birkenhead Lodge Retirement Home	Provider

Information was also obtained from a prescription centre and the District Health Board.

Information gathered during investigation

Birkenhead Lodge Retirement Home

Birkenhead Lodge Retirement Home (the Home) is described as a 69-bed licensed retirement home, with no private hospital beds.[1] The Home is operated by a company, which holds certification for the facility. Ms C and her husband are shareholders and directors of the company, and Ms C is manager of the Home.[2]

At the time of Mrs A's admission, three registered nurses were employed: Ms C, Ms D and Ms I.[3] Ms D had worked at the Home since she arrived in New Zealand in March 2004.

Chronology

Mrs A (aged 92) was admitted to Birkenhead Lodge Retirement Home on 30 August 2006, initially for a six-week period of "respite care" while her son and his family were on holiday abroad. The medical history recorded on admission by Ms D stated that Mrs A suffered from dementia, osteoporosis and vitamin B_{12} deficiency. Ms D noted that Mrs A was confused and disorientated, and "wandering into other resident's rooms". She also recorded that Mrs A had a rash on her back. Ms D's final entry of 30 August stated: "All care given … requires total supervision."

A care plan was completed on admission, and one "Problem" was recorded: "Rash on back ?scabies".

On 18 October, Mrs A signed a contract to confirm that she would be a permanent resident at the Home.

On 25 October, a care plan was written which stated that there was a "high risk of falls" because of Mrs A's confusion and limited mobility. A "falls risk factors score card" was completed on that day. It confirmed that Mrs A was at a high risk of falls.

A pressure sore risk assessment was also performed on 25 October, which indicated that Mrs A was at a "high risk" of developing pressure sores.

No other documentation was completed by the Home in the period from 30 August until late October 2006. Daily progress notes commenced on 2 November 2006. Ms C stated that she was unaware of this omission at the time, and that the registered nurses involved in Mrs A's care (Ms D and Ms I) were primarily responsible for the completion of documentation. She stated that "as the Owner/Manager of the Home she reasonably expected the clinical staff to have completed the documentation".

[1] In the Home's publication *Resident information book for rooms* (27 January 2003).

[2] References in this opinion to Birkenhead Lodge Retirement Home include the rest home company.

[3] Ms I subsequently left, and at the time of Mrs A's admission to hospital, Ms C and Ms D were the only permanent registered nurses. Ms D left the Home in July 2008.

Falls

The Home provided incident forms that described Mrs A falling or sustaining injuries such as skin tears seven times over the following months.[4] According to the incident forms, Mrs A's family were advised of only one of these falls, that of 3 May 2007. Ms C stated that Mrs A's family was not informed because:

> "The Resident Contract states that residents' relatives will be notified of incidents only if incidents are potentially serious, result in serious harm, or the Manager believes that notification of the relatives is warranted."

According to the progress notes, Mrs A also fell, or skin tears occurred, on four other occasions when an incident form was not completed.[5] Two of these occasions are worthy of note. On the night of 20 March 2007, Mrs A was found on the floor and transferred to hospital the next day. She was admitted for seven days and treated for cellulitis. On another occasion, Ms C was advised on 27 July 2007 that Mrs A had fallen, which had resulted in a "small laceration on scalp". Ms C did not think this incident was one where an incident form was required. However, the clinical record stated that the registered nurse on duty kept "close observation" after Mrs A had fallen; informed Ms C and the doctor of the incident; and recorded that Mrs A was "quite sleepy which is of concern". The doctor subsequently reduced Mrs A's blood pressure medication. The nurse added that "[Ms C] will attend to as from tomorrow".

Ms C stated:

> "[The completion of incident forms] was the primary responsibility of the Registered Nurses on duty at the time."

Ms D stated that each morning Ms C would take handover from the night staff and do the medicine round — Ms D did not start work until 9am.

March to June 2008

On 18 March 2008, Mrs A's condition deteriorated. Following discussion between general practitioner Dr E, the nursing staff and Mrs A's family, it was decided that she should receive only palliative care, because of her prognosis. However, Mrs A's condition improved, even though she remained in need of full nursing care.

On 5 June, Mrs A was recorded as being "unwell", and this observation was repeated in the progress notes the following day. On 7 June, the note from the caregiver states: "Looked very unwell … has a sore on her left hip … looks very painful." The following day the caregiver made a similar comment: "very unwell … very bad sore on her left side very painful".

In her response to the provisional opinion, Ms C stated that she was advised of a pressure sore on Sunday 8 June 2008. Ms C stated that she "immediately cleaned and

[4] 11 February, 3 May, 25 July, 17 September, and 28 November 2007; and 5 and 23 February 2008.

[5] 20 March, 6 May, and 27 July 2007, and 2 April 2008.

dressed the area, and the next day called the specialist wound care nurse [Ms F] to review the sore". There is no record in the progress notes of Ms C's actions.

Earlier, Ms C had stated that the registered nurses first knew of the sore on 9 June. She stated that the caregivers who provided Mrs A's care "did not report this hip ulcer any earlier to any senior staff … As soon as the RN and Manager were told there were steps put in place immediately to alleviate the problem."[6]

Ms D stated that on 9 June a caregiver drew her attention to a large pressure sore on Mrs A's left hip. Coincidentally, general practitioner Dr E and specialist wound care nurse Ms F were visiting the Home at the time. Ms D asked Ms F to review Mrs A. Ms F stated:

> "A phone referral was received from [Ms D] to review a male resident. I visited this man on 9 June 2008. While on this visit [Ms D] asked me to review [Mrs A].
>
> [Ms D] pointed out to me that she had only recently been notified of this issue and was not happy with the condition of the wound, or the health of the resident.
>
> [Mrs A] was in bed lying on her right side. Her left hip was covered with an incontinence pad. I removed this and found a Grade IV[7] pressure sore with a large amount of slough and necrotic tissue evident. I photographed and probed the wound and found a 3cm cavity extending below the wound edges. …
>
> I determined that the wound would have to be extensively surgically debrided. Infection was evident to the naked eye, with the presence of slough, redness, pain and exudate. There was also a possibility that the infection could have spread to the bone.
>
> [Mrs A] presented as looking underweight and frail. She was non-weight bearing and fully dependent on carers. I was unable to determine her weight as [the Home] did not have sitting weighing scales. I also noted that [Mrs A] had Grade II pressure sores on both heels and a Grade II pressure sore on her buttocks.
>
> The GP who visits [the Home], [Dr E], was present at the time of my visit. I asked if he would examine the wound and write a referral letter to facilitate admission to [the public] Hospital. He did this."

Dr E immediately referred Mrs A to hospital and she was admitted that day. No transfer letter was provided by the Home.

[6] Letter to HDC of 7 July 2008.

[7] Pressure sores are clinically graded in seriousness from I to IV (or 1 to 4). A Grade IV pressure sore has extensive destruction to tissue, tissue death (necrosis), or damage to muscle or bone, possibly with full thickness skin loss.

On admission to hospital, Mrs A was assessed as malnourished, and having pressure sores that would require surgical treatment.

Following further care in hospital, Mrs A's condition improved and she was eventually discharged to a private hospital.

Other matters

Medications
Mrs A was prescribed medicines to be taken at breakfast (Metoprolol or Betaloc,[8] Risperidone,[9] paracetamol, Alendronate, calcium carbonate, and cholecalciferol[10]), and paracetamol at lunch, tea, and bedtime.

The doctor's notes provided by the Home indicate that Mrs A was also prescribed antibiotics in early April 2007,[11] and on 19 February 2008, 26 March 2008, and 8 April 2008. There is no record that these medicines were administered.

Mrs A's medicines were provided in blister packs by a pharmacy. Following Mrs A's admission to hospital, the hospital pharmacist contacted the pharmacy on 11 June 2008, and subsequently recorded that the past administration by the Home of one of Mrs A's medicines, Alendronate (which was due to be given each morning for the treatment of osteoporosis) "is not guaranteed as further supply not often sought by rest home".

The process at the Home is that, once a patient has taken his or her medicines, a "Medication Administration Record" is signed by the administering nurse or caregiver, according to whether the medicines were given at breakfast, lunch, tea, or bedtime. This confirms that the medicines have been given. If the medicines have not been given, there is a section of the record for the registered nurse or caregiver to complete if a medicine was not given. This was never completed.

The Home provided the "Medication Administration Record" for the period from 5 February 2007 until Mrs A's admission to hospital on 9 June 2008. No earlier records were provided.

In the 16-month period from 5 February 2007 until 9 June 2008, the section of the Medication Administration Record relating to the administration of Mrs A's medicines was unsigned at breakfast on 304 occasions. It was also unsigned at lunchtime on 81 occasions, at teatime on 167 occasions, and at bedtime on 259 occasions, but only paracetamol was due to be given at those times.

[8] Metoprolol and Betaloc are prescribed to reduce high blood pressure.

[9] Risperidone was prescribed for the treatment of Mrs A's dementia, and was commenced on 18 February 2008.

[10] Alendronate, calcium carbonate and cholecalciferol are prescribed to prevent osteoporosis.

[11] The doctor's note of 17 April 2007 states that antibiotics were commenced five days earlier, subsequent to a telephone call to the doctor.

The Medication Administration Record was signed eight times on two days when Mrs A was not in the Home but in the public hospital (10 and 11 June).

Ms C has since accepted that the Medication Administration Record was not always completed accurately. However, she submitted that "it cannot be assumed that, because a medication is not recorded as having been given, it was not actually given".

The pharmacist/manager of the pharmacy, advised that Mrs A's drugs were placed in a blister pack at the pharmacy. She advised that the total cost charged by the pharmacy for Mrs A's prescriptions from 1 January 2007 until 30 June 2008 was $131.30. For this same period, Mrs A was charged a total of $780 by the Home (15 monthly charges of $50, and one of $30). The Home originally stated that the difference between the two sums was because the charges "did not include either the cost of packaging residents' medications in blister packs, or the cost of delivering pharmacy items to the [Home]".

In a subsequent statement, Ms C said:

> "[W]hile the [Pharmacy] charges include the cost of packaging, private residents pay Birkenhead Lodge an additional fee for pharmacy items."

Ms C confirmed that there was no formal agreement with Mrs A or her son to allow a "mark-up", but that this was now included in contracts for new private residents. Mr B stated that he was not aware that his mother would be charged a cost additional to the price of the pharmacy items, and he had not agreed to any such additional charge.

Podiatry costs

During Mrs A's residence at the Home, she was charged nine times for podiatry services, at a total cost of $510. These were provided by podiatrist Ms H until September 2007, and by a team of two podiatrists from September 2007 onwards. Ms H and the two other podiatrists stated separately that any care they provided to residents was recorded on index cards. These cards were retained at the Home. Ms H added that these were kept in Ms C's office.

The index card provided by the Home for Mrs A has four entries: 27 September and 29 November 2007, 6 March and 8 May 2008. The care provided was for toenails to be cut and filed, and "callous reduced". There are no entries by Ms H.

Ms H stated that she charged the Home $25 per resident; the two other podiatrists stated that they charged $40 per resident. From 27 December 2006 to 18 April 2007, Mrs A was charged $50 on three occasions. From 13 June 2007 to 16 April 2008, Mrs A was charged $60 on six occasions.

Ms C stated that charges were added "to cover the cost of administration, dressings, and nursing time assisting the podiatrist".

Ms H stated that the nursing staff at the Home did not assist her, and the sole responsibility of the nursing staff was to deliver and remove the resident after she had provided care.

Job descriptions

The Manager job description[12] sets out the requirement of the manager to "plan and implement ongoing care direction" in accordance with the standards set out by the Ministry of Health.[13] The job description also states that it is the manager's responsibility to ensure the completion of all nursing documentation, to monitor all accidents and incidents, and to ensure that accident forms are completed by staff and followed up.

The Registered Nurse (Owner) job description[14] sets out the responsibility to work with staff "to prepare a written comprehensive care plan for each resident", and to supervise the care of residents "who may need specialised nursing care, for example, … wound dressing". The job description includes the responsibility to "[train] staff to ensure that they adhere to care-plans", and to "[oversee] drug administration to ensure safe delivery of same".

Key responsibilities in the more general, Registered Nurse job description[15] are to "[work] with the manager and staff to prepare a written comprehensive care-plan for each resident", and the "maintenance of clinical records".

Ms C said that her role as Owner/Manager "is to establish systems, employ and train staff, and to have an audit role, rather than to provide hands-on clinical care and to check that every document is completed". She submitted that "it is not proper that she be held liable for individual lapses or errors by others".

Caregivers

Attempts were made by this Office to speak to caregivers at the Home. All those approached declined to be interviewed.

Subsequent actions

Ms C advised that a number of changes had been made at the Home since this incident:

> "Many initiatives have since been implemented in order to prevent such a recurrence. These include the employment of an Assistant Manager/QA Manager; additional RNs; changes to hand-over; a daily management report; on-floor supervision during showering; staff education on pressure care; a total body examination of all residents by RNs each month; changes to forms in order to make the task of form-filling by care-givers more sensible and relevant; an update

[12] Dated October 2000.

[13] See **Appendix**.

[14] The Home provided a copy of the job description, updated on 1 February 2008.

[15] Dated 16 September 2007.

on the Waterlow Assessment for all clients; and preventative measures to be implemented for all scores above 10."

In her response to the provisional opinion, Ms C included a copy of a new policy regarding the administration of medications. Ms C also advised that, while the Home "does not accept the criticisms in the provisional opinion, as a gesture of good faith", the Home had refunded $498.70 to Mrs A in relation to the podiatry and pharmacy costs.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

RIGHT 2

Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

...

RIGHT 4

Right to Services of an Appropriate Standard

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

Relevant standards

The standards relevant to this case are: the Code of Conduct for Nurses (Nursing Council of New Zealand [NCNZ], March 2008); Safe Management of Medicines: A Guide for Managers of Old People's Homes and Residential Care Facilities (Ministry of Health, September 1997); Competencies for the registered nurse scope of practice (NCNZ December 2007); and New Zealand Health and Disability Sector Standards (Ministry of Health NZS 8134: 2001).

These standards are set out in the **Appendix** to this report.

Opinion: Breach — Ms C

Ms C was responsible for managing the Home and providing nursing services. As owner, manager, and one of the registered nurses, she held major responsibility and seems to have wielded significant influence over the staff.

Ms C's job descriptions show that she was responsible for the standard of nursing care as well as being involved in providing daily nursing care. As manager, she was responsible for the training of staff. She was also responsible for the monitoring of all incidents, and ensuring that incidents were documented and followed up. Overall, I do not consider that Ms C met her responsibilities in terms of ensuring that other staff provided appropriate nursing services or in providing those services herself.

Ms C stated that other registered nurses were responsible for the completion of documentation. However, in my view Ms C had a responsibility as the Home's manager to ensure that documentation was completed and of an adequate standard. She failed to meet this responsibility.

For the reasons set out below, I have found that Mrs A was provided with substandard care, and that Ms C breached Rights 4(1) and 4(2) of the Code. I am also of the view that her actions are of a seriousness that warrant the referral of both Ms C and Birkenhead Lodge Retirement Home to the Director of Proceedings.

Documentation
Mrs A was admitted to the Home for respite care in August 2006. She suffered from dementia and osteoporosis, and required "total supervision" (as described at the time by Ms D, the admitting nurse). However, other than the admission documents, no further clinical documentation was completed that recorded Mrs A's care until she was formally admitted as a resident in late October that year. Significantly, for a patient who required "total supervision" (and therefore her compliance with medication could have been suspect if she was self-administering), there was no documentation regarding her medication administration during this early period. Indeed, as no Medication Administration Record has been provided to HDC for the period prior to 5 February 2007, it is unclear what medication Mrs A was being administered from her arrival in August 2006 to 5 February 2007. Neither is it clear what care she was receiving or what "supervision" was provided prior to 25 October 2006, when the care plan was written, and 2 November 2006 when daily progress notes began.

While Ms C stated that this lack of documentation was the fault of the other registered nurses, her own job description as Manager makes it clear that it was her responsibility "[t]o ensure completion of all nursing documentation, general records

and daily administration duties". Furthermore, I do not accept that as manager and one of only three registered nurses at the Home, Ms C could be unaware that no records were being documented for Mrs A over a period of almost six weeks.

The completion of the incident forms was also haphazard. There were many instances when incident forms were not completed despite Mrs A suffering an injury. Again, Ms C has blamed other staff for this failure, yet one of her responsibilities as Manager was:

> "Monitoring of all accidents/incidents and ensuring accident forms are completed by staff and followed up."

In particular, I note that on 27 July 2007, Ms C was informed of a fall that resulted in a "small laceration" on Mrs A's scalp. However, Ms C completed no incident form. In her response to the provisional opinion, Ms C stated that an incident form was not required in this instance. This is of concern. Mrs A had fallen and sustained an injury, and the registered nurse was sufficiently concerned by Mrs A's condition to call both Ms C and the doctor, who subsequently altered Mrs A's blood pressure medication. Even to a layperson, this appears to be a circumstance in which an incident form should be completed and the family informed.

In another case involving care provided to a resident of a rest home who developed pressure sores,[16] the Commissioner was provided with the following advice from independent nursing expert Dr Stephen Neville:

> "Careful, meticulous and appropriate documentation that gives a factual account of a client's health and well-being is integral to professional nursing practice. All nursing documentation forms the cornerstone of the clinical decision-making process and the making of professional nursing judgments[17] … In addition comprehensive documentation provides an audit trail of the clinical decision-making processes undertaken by nursing staff that have resulted in the provision of care."

Mrs A was a vulnerable resident who required total supervision, and who had been assessed as being at high risk of developing pressure sores and of falling. In my view, failing to regularly complete clinical documentation in the early period of Mrs A's admission, and the haphazard approach to incident reporting, was inappropriate for a resident with Mrs A's particular needs.

[16] See http://www.hdc.org.nz/files/hdc/opinions/04hdc08400resthome.pdf (21 December 2005).

[17] Thompson, C. & Dowding, D. (Eds) (2002). Clinical decision-making and judgement in nursing. Edinburgh: Churchill Livingstone.

Medication

According to Mrs A's Medication Administration Record, from 5 February 2007, the administration of her medications was erratic at best. In particular, on 304 occasions in a 16-month period the record was not signed to signify that the morning medicines were given. I note that the three drugs[18] prescribed to treat Mrs A's osteoporosis were all due at breakfast time, as were the medicines to treat her dementia and high blood pressure. The public hospital pharmacist noted a concern that Mrs A had not been receiving her Alendronate as the Home had not been requesting further supplies. For a person who was assessed as a high risk for falls (and with a correspondingly large number of falls), the failure to administer the drugs specifically prescribed for the treatment of osteoporosis is particularly serious.

In addition, on four occasions from April 2007 to May 2008, Mrs A was prescribed antibiotics, yet there is no corresponding record to show that these medicines were actually given.

Ms C was responsible for administering the medication on the morning drug round. In addition, Ms C's job description sets out her responsibility to oversee drug administration "to ensure safe delivery of same". Ms C's responsibilities are also set out in the Ministry of Health's document "Safe Management of Medicines: A Guide for Managers of Old People's Homes and Residential Care Facilities".[19] It is clear that in Mrs A's case, Ms C failed to meet her responsibilities both as a registered nurse administering drugs, and as the manager.

In her response to the provisional opinion, Ms C accepted that the record was "not always completed accurately", but that "it cannot be assumed that, because a medication is not recorded as having been given, it was not actually given". However, Baragwanath J stated in his decision in *Patient A v Nelson–Marlborough District Health Board*[20] that it is through the medical record that health care providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). In my view this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted. Furthermore, the failure to record medications given is poor practice, affects continuity of care, and puts patients at real risk of harm. For instance, in the absence of good documentation, Mrs A was as much at risk of being given an overdose as receiving no medicine at all from those responsible for her care.

In the latter period of Mrs A's residence at the Home, the breakfast medications are recorded as having been given regularly. On the surface, this would seem to be of no

[18] Alendronate, cholecalciferol, calcium carbonate.

[19] See **Appendix**.

[20] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV–2003–204–14, 15 March 2005).

concern. However, the Medication Administration Record was signed to state that Mrs A was given drugs on eight occasions (four times each on 10 and 11 June 2008) when she was not physically present at the Home. This raises serious questions about whether the record has been falsified. At the very least, I am left with real doubt about its accuracy.[21]

Pressure sore
On 9 June 2008, Ms D became aware of a very large pressure sore on Mrs A's hip and followed up with Ms F. Ms C stated that no care had been provided for this sore because the caregivers had not brought it to the attention of the registered nursing staff.

Attempts were made by this Office to speak to the caregivers who provided care to Mrs A in June 2008 to clarify this point, but they declined to be interviewed.

In her response to the provisional opinion, Ms C claimed that she was informed of the pressure sore on 8 June, cleaned and dressed it, and she was the one who called Ms F about the sore the following day. This account is markedly different from Ms C's letter to HDC of 7 July 2008. In that letter, she made no reference to being informed of the sore on 8 June, no mention of any actions she has now claimed, and clearly stated that the first the registered nurses (including herself) knew of the sore was on 9 June. There is no evidence to support Ms C's latest account. There is no record in the progress notes that Ms C was informed of, or treated the wound, and Ms F is clear in her recollection that she had not been called to attend Mrs A. She was coincidentally at the Home when asked by Ms D to review Mrs A on 9 June.

It is difficult to believe that the development of the large sore described by specialist wound care nurse Ms F could be missed, and that the caregivers did not bring it to the attention of either Ms D or Ms C. Certainly there is evidence in the progress notes that Mrs A was unwell from 5 June and the sore was noted from 7 June by caregivers.

If one accepts Ms C's submission that the caregivers simply did not tell the registered nurses about the pressure sore, then serious questions arise about the adequacy of training and supervision given to caregiving staff by Ms C. As stated in the Nursing Council of New Zealand's document *Competencies for the registered nurse scope of practice* (December 2007), a registered nurse "Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others". Ms C was both registered nurse and manager. Furthermore, her job description as "registered nurse (Owner)" sets out her responsibility to supervise the care of residents "who may need specialised nursing care, for example, … wound dressing". The job description also includes the responsibility to "[train] staff to ensure that they adhere to care-plans".

[21] I note that similar issues have been raised in another complaint about the Home and Ms C, currently being investigated (08HDC08672). In that case, the record was signed to state that the medicines had been given on nine occasions when the patient was actually in hospital.

The simple fact is that this was a very large pressure sore (graded as IV by Ms F, the most serious grading) which should have been prevented by good nursing care or at least identified and treated earlier. I do not accept that it was solely the fault of the care staff that this sore developed to such a serious degree unbeknownst to the registered nurses, particularly when the progress notes also suggest something was amiss four days before the sore was appropriately treated. Neither do I accept that Ms C took appropriate action once it came to her attention. It was clearly Ms C's responsibility as manager and registered nurse to not only supervise staff, but also ensure that appropriate care was provided to Mrs A to prevent pressure sores and treat any that developed — particularly when Mrs A was known to be at high risk.

Summary
The documentation of Mrs A's care was woefully short of an acceptable standard, with large gaps in her progress notes, a care plan that until October 2006 did not address her falls risk, and inadequate incident reporting and recording of medications given. In my opinion Ms C was responsible for these failings, and breached Right 4(2) of the Code.

Mrs A developed a serious pressure sore which was not identified and treated early enough. On a significant majority of days Mrs A did not receive her morning medication. Ms C was personally responsible for administering this, as well as being responsible, as manager, for monitoring the medication administration standards of others and supervising Mrs A's care. Mrs A was not provided with care of a reasonable standard, and in accordance with professional standards. Accordingly Ms C breached Rights 4(1) and 4(2) of the Code.

Opinion: Breach — Birkenhead Lodge Retirement Home

Clinical care

Birkenhead Lodge Retirement Home was obliged to provide services to Mrs A with reasonable care and skill and in compliance with relevant standards, such as the Health and Disability Sector Standards and the Health and Disability Sector Standards.[22] In my opinion the Home failed to discharge its obligations.

I have set out in detail, above, the lapses in Mrs A's care. These include inadequate care resulting in a severe pressure sore that was not identified and treated early enough, and poor documentation, particularly in the early stage of Mrs A's residence

[22] See **Appendix**.

at the Home. I also note that this is not the first time the Home or Ms C have been sanctioned by HDC for inadequate documentation.[23]

While I consider that, as a registered nurse, manager and owner of the Home, Ms C holds personal responsibility for the standard of care Mrs A received, it is clear that other staff were involved in her care. In my opinion, the evidence points towards a systemic problem at the Home that resulted in Mrs A receiving a poor standard of care, and resulted in inadequate documentation of care. Clearly it was common practice for care not to be documented for Mrs A; for falls and other incidents not to be consistently reported; and, according to Ms C, caregivers did not consider it necessary to inform the registered nurses that Mrs A was developing a serious pressure sore. Birkenhead Lodge did not provide Mrs A with reasonable care in accordance with relevant standards, and therefore it breached Rights 4(1) and 4(2) of the Code.

Financial exploitation

Mrs A also had the right to be free from financial exploitation.[24] She was a vulnerable rest home resident who was unable to advocate for herself. The invoices were trusted to be accurate and to appropriately reflect the care she was provided. For the reasons given below, in my view Mrs A was financially exploited by the Home. She was charged for services that were not provided, or excessively charged for services provided.

Podiatry
The podiatrists who provided services to residents of the Home documented their care on index cards kept at the Home, and they charged either $25 or $40 per resident. Mrs A's index card, with details of just four podiatry appointments, was provided by the Home.

However, during her residence at the Home, Mrs A was charged for a total of nine podiatry visits (for a total of $510), at either $50 or $60 each time. The Home stated that the "mark-up" of $20 or $25 was because of the extra work to the nursing staff, the dressings, and the administration costs. However, according to podiatrist Ms H, the nursing staff merely brought residents and collected them afterwards. The podiatrist team's record of four visits to Mrs A indicates that she required no dressings. As to charging an "administration fee", that is barely credible.

In any event, on the basis of the evidence provided, Mrs A was provided podiatry services on only four occasions, at what should have been a cost of $160. There is no evidence that the other five visits she was charged for actually occurred.

[23] See 07HDC12520 (29 April 2008). There is also another complaint under investigation (08HDC08672).

[24] Right 2 of the Code.

Pharmacy costs
According to the pharmacy where Mrs A's drugs were dispensed, the total cost for the dispensing of the drugs from 1 January 2007 until the end of June 2008 was $131.40. However, during this same period Mrs A was charged $780 by the Home. The difference in cost, according to Ms C's initial statement, was due to the costs of transporting the drugs from the pharmacy, and the cost of the blister packs. She subsequently amended her statement to say that the pharmacy cost included the packaging.

In short, I do not accept that it would have cost over $40 on average each month to transport Mrs A's drugs from the pharmacy to the Home. While Ms C has subsequently changed the contract for private patients so that such a mark-up is agreed, she accepted that there was no such agreement with Mrs A, and Mr B was unaware of such a mark-up.

While Ms C appears to feel that the Home satisfies its responsibilities by including a statement in the contract that allows a mark-up on pharmacy items, a mark-up of over 500% (to $780 from $131) is clearly exorbitant, and in my view is in itself exploitative.

Summary
The Home has provided no good reason for the excess costs charged to Mrs A in relation to her podiatry care, and the excessive pharmacy costs.

In her response to the provisional opinion, Ms C has provided details of a refund of $498.70 to Mrs A. Ms C also advised that the Home has "changed these charging practices".

The Home's refund is appropriate, nevertheless it does not change my view that the Home financially exploited Mrs A. Accordingly, Birkenhead Lodge Retirement Home breached Right 2 of the Code. I will bring this to the attention of the DHB, and recommend a financial audit.

Follow-up actions

- Ms C and Birkenhead Lodge Retirement Home will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Nursing Council of New Zealand, recommending that Ms C undergo a review of her competence to practise as a registered nurse.

- A copy of this report will be sent to the Ministry of Health and the DHB, recommending that a financial audit of Birkenhead Lodge Retirement Home is performed.
- Upon completion of the Director of Proceedings' process, and subject to any submission orders, a copy of this report with details identifying the parties removed, except the name of Birkenhead Lodge Retirement Home, will be sent to HealthCare Providers New Zealand, the Association of Residential Care Homes, the New Zealand Nurses Organisation, and the Quality Improvement Committee, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director brought a charge before the Health Practitioners Disciplinary Tribunal alleging professional misconduct by Ms C. The charge comprised a number of allegations arising out of care provided to three separate rest home residents over a period of two years.

There were multiple problems relating to the care of residents (including inadequate care by Ms C herself), as well as management issues and a failure to maintain adequate documentation. Ms C also misled the Health and Disability Commissioner by forwarding to him an incident form she had re-written.

The Tribunal upheld the charge in a decision dated 10 December 2009 and imposed the following conditions:

- Supervision for 12 months;
- Not to practice in a sole charge or supervisory role for three years.

The Tribunal also recommended a competence review before re-issue of an annual practising certificate. Ms C was censured, fined $7,500 and ordered to pay costs to HDC and the Tribunal totalling $18,500.

The Health Practitioners Disciplinary Tribunal's decision is available at: http://www.hpdt.org.nz/portals/0/nur09123ddecanon.pdf

Claims against Birkenhead Lodge in the Human Rights Review Tribunal are pending.

Appendix

Relevant standards

Code of Conduct for Nurses (Nursing Council of New Zealand [NCNZ], March 2008)

> "Some examples of behaviour which could be considered as a basis for a finding of professional misconduct or imposing a penalty are listed below:
>
> …
>
> attempting to defraud, dishonest dealings and/or falsifying records."

Safe Management of Medicines: A Guide for Managers of Old People's Homes and Residential Care Facilities (Ministry of Health, September 1997).

> "…
>
> Every manager of a residential care facility must take all reasonable steps to ensure that at all times the storage, administration and disposal of medicines are strictly controlled and that safety, efficacy and accuracy are maintained with respect to 'the right dose being administered to the right person in the right form at the right time'; as prescribed by the medical practitioner.
>
> …
>
> **Administration procedure**
>
> …
>
> 6. Record on the Medication Administration Record sheet that the medicine has been administered and taken, by signing in the space provided. The sheet should also allow the recording of withheld doses, refused doses or extra doses given in the event of wastage.
>
> …"

Competencies for the registered nurse scope of practice (NCNZ December 2007)

> "Competency 1.3 Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others.
>
> …
>
> Competency 2.1 Provides planned nursing care to achieve identified outcomes.
>
> …

Competency 2.3 Ensures documentation is accurate and maintains confidentiality of information."

New Zealand Health and Disability Sector Standards (NZS 8134: 2001), Ministry of Health.

"…

Standard 2.5: the day to day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate and safe services to consumers/kiritaki.

…

Standard 5.2: Consumer/kiritaki records are accurate, reliable, authorised and comply with current legislative and/or regulatory requirements.

Standard 5.3: Consumers/kiritaki receives medicines in a safe and timely manner that comply with current legislative and regulatory requirements.

…"