Kingswood Healthcare Morrinsville Limited (trading as Kingswood Rest Home)

Ms D
RN E

A Report by the

Aged Care Commissioner

(Case 20HDC00526)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Mrs A and Mr B via the Nationwide Health and Disability Advocacy Service about the services provided to their late father, Mr C, at Kingswood Rest Home. The following issues were identified for investigation:

- *Whether Kingswood Healthcare Morrinsville Limited (trading as Kingswood Rest Home) provided [Mr C] with an appropriate standard of care in [Month1][1] and [Month2] 2019.*
- *Whether following receipt of [Mr C's] family's complaint, Kingswood Healthcare Morrinsville Limited complied with Right 10 of the Code of Health and Disability Services Consumers' Rights.*
- *Whether [Ms D] provided [Mr C] with an appropriate standard of care in [Month1] and [Month2] 2019.*
- *Whether following receipt of [Mr C's] family's complaint, [Ms D] complied with Right 10 of the Code of Health and Disability Services Consumers' Rights.*
- *Whether [RN E] provided [Mr C] with an appropriate standard of care in [Month1] and [Month2] 2019.*

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

3. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer's daughter
Mr B	Complainant/consumer's son
Kingswood Rest home	Provider
Ms D	Provider
RN E	Provider/registered nurse

4. Further information was received from:

Ms F	Provider/enrolled nurse
Mr G	Provider/senior caregiver
Mr H	Provider/healthcare assistant
RN I	Provider
Ms J	Provider/administrator and activities coordinator
Ms K	Provider/senior caregiver and clinical assistant
RN L	Provider

[1] The relevant months are referred to as Month1 and Month2 to protect privacy.

HCA M	Healthcare assistant
HCA N	Healthcare assistant
Ms O	Provider/caregiver
Health New Zealand|Te Whatu Ora (Health NZ)	

5. In-house clinical advice was obtained from Registered Nurse (RN) Jane Ferreira (included as Appendix A).

Information gathered during investigation

Introduction

6. Mr C, aged 90 years at the time of events, had previously been residing at a care home. He was transferred to the Kingswood Healthcare Morrinsville care home (Kingswood) in Month1 2019 and admitted into the male-only dementia unit. During his admission he became unwell, and on 6 Month2 2019 he was transferred to a public hospital with severe bilateral pneumonia. The decision was made to provide comfort cares and, sadly, he passed away. I extend my sincere condolences to Mr C's family.

7. This report examines the care provided to Mr C at Kingswood during his nine-day admission, and in particular the adequacy of the assessments and care provided, timeliness of escalating his care when he became unwell, and communication with his enduring power of attorney (EPOA) and family.

Background

8. Mr C's medical history included atrial fibrillation (irregular heart rhythm), hyperlipidaemia (high level of fat particles in the blood), hypertension (high blood pressure), osteoporosis (brittle and fragile bones), polymyalgia (muscle pain and stiffness), and dementia mate wareware. Mr C was independently mobile with a walking frame and required moderate supervision with activities of daily living.

9. Mr C's EPOA for personal care and welfare was his son, Mr B. The clinical records state that the EPOA had been activated by a medical certificate of incapacity in 2018, meaning that Mr B would make decisions about Mr C's health care as Mr C was 'mentally incapable' of doing so himself.

Key Kingswood staff members involved

10. Kingswood's senior staff member, Ms D, is based at Kingswood. She told HDC that she is not qualified as a registered nurse.

11. RN L was based at the first care home. RN L is registered with the Nursing Council of New Zealand.

12. The registered nurse at Kingswood at the time of events was RN E. She told HDC that this was her first job after her completion of the CAP and she worked at Kingswood in 2019. She was also required to be on call after hours for any calls from the healthcare assistants.

13. In response to the provisional opinion, Kingswood told HDC that while RN E was a newly registered nurse in New Zealand, she was not an inexperienced or new graduate nurse, having worked as a registered nurse for over six years as a ward nurse and emergency ward nurse in different city hospitals overseas, and many of the responsibilities she listed as being part of her job in these roles are tasks that a registered nurse in any care home would cover every day. Kingswood said that she had also previously worked as a healthcare assistant in a care home.

14. RN E told HDC that she was the only registered nurse working at the 42-bed facility, which had three units — the rest home, the dementia care unit, and a male-only dementia unit. Kingswood confirmed this and stated that this was in accordance with the Age-Related Residential Care (ARRC) agreement.

15. RN E said that when she started her employment, RN L came to Kingswood and gave her three days of orientation. RN E then went to the first care home and had a two-day orientation there, as she was required to provide the care home with cover and needed to be familiar with its layout. Kingswood stated that five days' orientation is thought to be acceptable for an experienced nurse, and that other than at orientation, RN E did not work at the care home and was not 'required to cover'.

16. In response to the provisional opinion, RN E stated that Kingswood is seeking to emphasise her experience as a registered nurse, but before offering her a job, Kingswood was well aware that she was new to New Zealand. RN E noted that there is an absence of information to indicate the support and training needs that might be required for a nurse newly practising in New Zealand, regardless of their experience in other countries. She also changed her previous statement and said that her orientation was three days (two days in the first care home and one day in Morrinsville), not five days.

17. Job descriptions for these roles and relevant guidance available to Kingswood staff can be found in Appendix B.

Mr C's admission process — 29 Month1 2019

18. Mr C was transferred from the first care home to Kingswood on 29 Month1 2019. The reason for transfer to Kingswood is not immediately clear from the clinical notes, but it was documented in the 'family discussion notes' from the first care home five days prior to transfer that Mr B had been contacted to discuss Mr C's sexually inappropriate behaviour[2] and transferring him to Morrinsville (Kingswood), and that Mr B had no objections regarding the transfer. This reasoning also appears to be confirmed in more recent evidence provided by Kingswood (see paragraph 21).

[2] It is noted that the interRAI assessment in 2019 refers to Mr C having a history of sexualised behaviour towards female residents.

First care home's documentation

19. The nursing progress notes from the first care home indicate that on 29 Month1 2019, a nursing handover was provided to the nurse at Kingswood, and that Mr C's family had been informed of the transfer.

20. Kingswood told HDC that Mr C was seen by his GP the day before his transfer, and his admission weight and observations were 'carried over' from the first care home. Kingswood said that this was completed by RN L to assist the Kingswood nurse. However, HDC has not received relevant clinical notes related to this, nor are there any recordings of observations or weight in the Kingswood notes (for Mr C's entire admission).

21. Late in HDC's investigation,[3] Kingswood also provided a copy of a typed short-term care plan completed by Enrolled Nurse (EN) F, which was dated and countersigned on 29 Month1 2019 by (it appears) Ms D. EN F told HDC that she was working at the first care home that day, so it appears that this was created prior to Mr C's admission to Kingswood. It is documented that the plan was prepared for Mr C's new admission to the Kingswood unit, and the goal was to settle and orientate him to his new home. It states that Mr C was a very high falls risk and that he required regular safety checks. It is recorded in this care plan that the reason for transfer was 'due to sexually inappropriate behaviour towards female staff and residents', and male staff were to complete personal cares if possible.

22. However, there is no evidence of details of the rationale for change in care circumstances, or whether Needs Assessment and Service Coordination (NASC) services were involved in Mr C's review and transfer of care process. Mr C had a continuing care plan in place, and his most recent interRAI assessment had been completed at the first care home. Both documents include his care requirements and agreed support, but this was at the time of those assessments, which was at least five months earlier.

23. There is no record of nursing information such as a transfer/discharge form, Mr C's health status, his medication management, the time of transfer, or the transport processes.

24. In response to the provisional opinion, Kingswood again belatedly provided further clinical notes to HDC, namely an electronic progress note by RN L dated 31 Month1 2019 (two days after transfer), stating:

> '[Mr C] has been moved to Kingswood Rest-home in Morrinsville on 29/[Month1]/2019. [Mr C] has been exhibiting some sexually inappropriate behaviour to another female resident and after discussion with the family [Mr C] has been moved to the men's only unit in Morrinsville.'

25. In response to the provisional opinion, Kingswood told HDC that RN L had accompanied Mr C for his transfer, as well as a male member of staff, and would have provided a handover to RN E. As noted above, the nursing notes do indicate that a handover occurred,

[3] It is noted that this was provided in response to HDC's in-house advisor's report, and had not been provided in response to HDC's three previous information requests.

recording: '[Mr C] is getting transferred to Kingswood Morrinsville. Given the handover to the nurse. Family informed.'

26. However, there is no indication in the clinical record as to whether this was in person. RN E stated that while Kingswood now asserts that RN L 'would have' provided RN E with a detailed handover, there is no evidence from the information provided that supports this claim. RN E disagrees with the suggestion that RN L provided a face-to-face handover when Mr C was admitted. RN E's recollection is that any transfers were managed solely by a driver employed by the organisation, and the registered nurse did not accompany residents who were being transferred. RN E stated that the only time she interacted with RN L in person was during her three-day orientation.

Kingswood documentation

27. Mr C was admitted to Kingswood by RN E. The progress note recorded by RN E at 3pm on 29 Month1 2019 states: 'Admitted [Mr C], transferred from [the first care home], walking with frame, confused, and settled after he was given tea. Admission cares done.'

28. There are no further nursing notes in Mr C's records for his entire admission at Kingswood.

29. RN E's entry does not introduce Mr C as a new resident or discuss his care and safety needs. There is no record that admission nursing assessments such as falls risk, pain assessment, or skin assessment were completed or that Mr C's weight and baseline observations were recorded. There is no behaviour monitoring plan, or a specific nursing plan with Mr C's individualised care and safety needs.

30. In response to the provisional opinion, Kingswood provided a handwritten note dated 29 Month1 2019, discussing admission matters for Mr C, and suggested that this was written by RN E. This had not been provided to HDC in response to previous information requests. Kingswood considered that this showed that a full nursing handover had occurred. However, RN E advised that this was not her handwriting and not written by her.

31. There is also no record of communication with the EPOA or other family members from Kingswood staff to inform them of Mr C's arrival at Kingswood or to involve them in the admission process. There is no record in the family/whānau contact form of any interaction between Mr B and Kingswood during Mr C's entire admission.

32. In a later response to HDC, Kingswood provided a copy of a typed short-term care plan (described in paragraph 21 above).

33. Also in a later response,[4] Kingswood provided a 'behaviour chart' for Mr C, which covered 29 Month1 2019, had no records for 30 Month1 2019 and 31 Month1 2019, and then covered 1–3 Month2 2019. The chart was not completed for every shift on these dates, and the notes that are contained mostly state 'no concerns'.[5] None of these entries are

[4] See footnote 2.
[5] Except for 2 Month2 2019 (discussed below).

signed and no name is recorded to indicate who completed these. It is unclear what behaviours in particular were being monitored.

Availability of Ms D and RN L during Mr C's admission

34. From 1–3 Month2 2019 the communication diary[6] has a sticker stating that senior caregiver Mr G was on call, not Ms D, and that RN E should be called for medical matters. The communication diary on 1 Month2 2019 also has an entry stating: 'EN on call if need[ed]. CM in [the first care home] on call if need[ed]. Between [Ms K] and [Ms J] will be available in my place.'

35. Ms D was on leave until 12 Month2 2019,[7] although she appears on Kingswood's staff roster during this period. Ms D told HDC that although she was on leave, she was available to be contacted any time, and RN E needed to report to RN L in Ms D's absence if any clinical issues arose. In response to the provisional opinion, however, HDC received contradictory dates of her period of leave; Ms D told HDC that she was on leave from 17 Month1 to 8 Month2 2019, and Kingswood told HDC that she was on leave from 18 Month1 to 12 Month2 2019.

36. It does appear that Ms D was contacted during this time — a communication diary entry on 3 Month2 2019, which appears to have been written by Mr G, indicates that Ms D gave directions to withhold another resident's breakfast and lunch PRN medications and for 'NO ONE to tell family. [Ms D] will do this.'

37. In a later response, Kingswood also said that an 'experienced EN' was working at the time, who was available to assist. However, EN F said that she was not working during Mr C's admission to Kingswood. She said that on the day of his admission, her car was stolen from outside the complex, and she did not return to work until 12 Month2 2019.

Initial admission period 29 Month1 to 3 Month2 2019

38. RN E stated that during the week that Mr C was in the facility, she would see him walking around talking to other residents, randomly asking about his wife, sitting in the lounge, or taking a nap. She said that she did not notice anything out of the ordinary to make her think he was unwell.[8]

39. The progress notes on 29 Month1 2019 indicate that Mr C had settled in and was eating and drinking well. No progress notes were recorded on 30 Month1 2019 or 31 Month1 2019.

40. Mr C did not receive a GP review within the first two days of his admission. RN E told HDC that she was advised by the registered nurse who undertook her orientation that a resident needed to be enrolled with the GP and be seen within the first week of admission.

[6] The communication diary appears to be a method for Kingswood staff to leave requests and reminders for each other, both in relation to residents and other work matters.
[7] Her start date of leave was 3 Month2 2019, according to the statement of Ms K. Ms D confirmed that she returned to work on 12 Month2 2019 but did not confirm the start date of her leave.
[8] Prior to 5 Month2 2019.

In response to the provisional opinion, Kingswood confirmed that the instructions were to enrol a resident with the GP within the first week of admission.

41. On 30 Month1 2019 the GP charted a medication sheet for Mr C's regular, PRN, and topical drugs. Mr C's regular medications included clopidogrel, prednisone, folic acid, omeprazole, and paracetamol. No medication chart was provided to HDC by Kingswood, and the clinical notes contain no references to medication administration for Mr C's entire admission.

42. In response to the provisional opinion, Kingswood provided a medication signing sheet of medication administration by both care homes for 7 Month1 to 2 Month2 2019. This had not been provided to HDC in response to previous information requests. This appears to confirm that Mr C's regular medications were provided at breakfast, lunch, and dinner. However, there is not a chart of Mr C's last three days at Kingswood (4–6 Month2 2019).

43. The progress notes on 1 Month2 2019 indicate that Mr C was eating and drinking well, but on 2 Month2 2019 at 1.30pm, another HCA documented that Mr C had a 'sleepy presentation' and had eaten only a small amount of his breakfast. This is not noted in the communication diary. The 'behaviour chart' for this date[9] documented that Mr C was wanting to go to bed and kept falling asleep.

3 Month2 2019

44. On Sunday 3 Month2 2019 a communication diary entry noted that Mr C was to see the nurse because he had mucous in his right eye, was sleeping a lot, and appeared uncomfortable. The entry is unsigned and no time is recorded.

45. Senior caregiver Mr G stated that he requested this, and he expected RN E to see Mr C the next day.

46. RN E told HDC that she cannot recall seeing the note made in the communication diary on 3 Month2 2019. She said that her practice was to review the communication diary every morning, and if the note had been written on Sunday 3 Month2, she would have seen it on the Monday morning when she came to work. She stated: 'If the note was there, I could have requested that [Mr C] be seen by the GP with the other residents that day.'

47. The progress notes contain no mention of eye redness or discharge, or that concerns were reported to the registered nurse on this date — rather, the progress notes at 1.50pm describe Mr C as very talkative and eating well, with no concerns.[10] The next entry is at 11pm by HCA M,[11] who noted that Mr C was settled, ate and drank well, and went to sleep at 7.30pm, although his right foot was swollen.

[9] Under the PM shift.
[10] Signed but unclear which staff member made this entry.
[11] Kingswood told HDC that HCA M has left Kingswood and it has been unable to contact him for a statement.

Deteriorating condition

4 Month2 2019

Morning shift

48. No progress notes or communication diary entries were made for the morning of 4 Month2 2019.

49. HCA H told HDC that on 4 Month2 he went to see RN E personally because of his 'concerns' about Mr C. However, the contemporaneous records do not document what these concerns were.

50. HCA H said that RN E instructed him to push fluids and to get a urine specimen, but they were unable to obtain one because Mr C was not passing urine. He stated that the registered nurse was informed of this, and normally the nurse would sight the resident, then put in place a short-term care plan and contact the doctor, but none of this was done.

51. The above events are not documented in the clinical notes and there is no record of any assessment of Mr C at that time. HCA H said that at the end of his shift, he handed over to the staff at the shift changeover what had been happening during the day, both verbally and on the handover sheet. However, there is no record of either handover.

52. HCA H stated that he completed an incident form about these events (in 2020) after the complaint was received from Mr C's family. However, HDC received an incident form completed by HCA H dated 18 Month2 2020 (12 months after the events), in which he documented:

> 'On [4 Month2] I verbally went down to see the RN regarding [Mr C's] conditions as he was coughing up mucus and his eyes were weeping and also had a high temperature. I had asked if she could please come up to the men's unit to sight [Mr C] straight away.'

53. As outlined above, RN E cannot recall Mr C being unwell until 5 Month2. In response to the provisional opinion, she also noted that HCA H referring to 'get a urine specimen' were instructions she gave on 6 Month2 2019, not 4 Month2 2019 (discussed below).

54. HCA H said that all the staff members were aware that at any time '24/7' they were able to contact Ms D regarding the care of any resident and, in hindsight, that should have been done regarding Mr C. HCA H stated: 'I apologise for not ringing [Ms D] even though she was on leave.'

Afternoon shift

55. An entry in the communication diary by HCA M noted that Mr C's right foot was swollen and RN E was asked to check it. The time of the entry is not recorded, and the entry has been 'crossed out', and it is unclear who did this and when. There is no evidence that RN E took any action in response to the entry.

56. The only progress notes on 4 Month2 2019 were entered at 10pm and reported that Mr C was 'up and down', was wanting to get up for a walk often, had not taken his dinner, and was in bed at 5pm. This appears to have been documented by HCA M.

5 Month2 2019

57. The progress notes at 3.35pm on 5 Month2 2019 record that Mr C was in bed all day following a vomiting episode. The notes state: '[Mr C] spewed once this morning he's only been drinking fluids nothing to eat and in bed all day.' This appears to have been documented by HCA H, who was working until 4pm that day. There is no record that the carers escalated concerns to RN E, or that any nursing assessment occurred at that time.

58. RN E cannot recall seeing the above note (and noted that this was documented at the end of the HCA's shift). She said that if she had been advised that Mr C was vomiting, she would have raised this with the GP.

59. However, in her initial statement to HDC, RN E said that on 5 Month2, HCA N[12] (rostered on from 6am until 2pm) told her that Mr C was unwell, and they went to his room together. RN E said that Mr C was lying on his bed asleep and looked unwell, and the HCA told her that he was not eating.

60. In her second statement to HDC, RN E said that she was not informed that Mr C had vomited and had not eaten anything on 5 Month2 2019, and she was unaware of this. She stated that it was not until 6 Month2 that she was informed that Mr C had had only fluids the previous day.

61. In her initial statement, RN E said that she asked the staff to offer Mr C sips of water. She said that his skin was warm to touch but there was no fever when she checked his temperature, and he had a productive cough.

62. In her second statement, RN E recalled that she asked the caregivers to provide full cares to Mr C on his bed and to make him comfortable. She said that she asked them to ensure that he was offered water from a cup with a straw and to assist him with meals in bed, and she told the caregiving staff to provide him with paracetamol as needed. The HCAs were to notify her if they had any concerns, and she noted that she did not receive any calls from the caregiving staff on the afternoon or night shift. RN E did not record these events.

63. RN E told HDC that she took Mr C's observations, and her normal practice was to record observations in a progress note as residents' standard monthly observations were recorded on a separate sheet. She stated:

> 'I can see that there is no nurse progress note on 5 and 6 [Month2] and I cannot now explain why that is … It may also have been that due to time limitations and the backlog in uncompleted documentation … I did not have time to record the observations in the progress note before my shift ended on those days.'

[12] Kingswood told HDC that HCA N has left Kingswood and it has been unable to contact her for a statement.

64. RN E did not contact Mr C's family on this date. She said that it was not clear to her that the registered nurse needed to inform the family when a resident became unwell, and, until that point, Ms D would tell her if she needed to call a family member or would ask one of the caregivers to do so. RN E told HDC that she was not given any information about contacting families when she started working at Kingswood.

65. RN E said: 'It was not clear to me that I was expected or required to contact all residents' families or that I needed to contact Mr C's family on 5 [Month2] 2019.'

66. In response to the provisional opinion, Kingswood advised that RN E had had many family discussions during her employment, and provided two other patient examples, and therefore disagreed with these comments.

67. There is no evidence that RN E contacted Ms D or RN L for support. There is also no evidence that RN E contacted the GP for a review of Mr C's condition, although there is an email record from 5 Month2 2019 at 2.28pm, from RN E to a GP clinic, providing a list of residents who were due for their three-monthly review, with Mr C included in this list and noted as 'ENROLMENT New Resident'.

68. In her initial statement, RN E said that she called the GP clinic on 5 Month2 2019 and asked for Mr C to be seen by the GP when he attended that day. She cannot recall why Mr C could not be seen that day, but said that the GP came to visit another resident, so she asked him to see Mr C as well, and took the GP to Mr C's room and described his observations. RN E stated that the GP told her that he would see Mr C the following day as per his booked GP appointment.

69. In her second statement, RN E said that when she spoke to the GP during his visit, she was told that he could not see Mr C that day and Mr C had to be enrolled before an appointment could be arranged. She stated that she had already arranged Mr C's enrolment with the GP practice within a day or two of his admission, and when she spoke to the clinic, she was informed that Mr C would be enrolled as of 6 Month2 2019, so she organised an appointment for him. However, the evidence HDC has received indicates that RN E completed the enrolment forms on 6 Month2 2019 (discussed below).

6 Month2 2019 — transfer to hospital

70. RN E told HDC that on 6 Month2 2019 Mr C looked weaker and frailer. She recalled that the HCA said that she had tried to feed him but he was not eating, and he was sweating, so they decided to put him in a singlet with a blanket covering him. RN E cannot recall what time she was advised by the HCA that Mr C had deteriorated.

71. RN E said that to the best of her recollection, she took Mr C's observations and noted that he was coughing, had a dry mouth, and was sweaty. She said that she took his temperature, and he did not have a fever. As stated, there is no registered nurse entry in the progress notes for that day. RN E said: 'I do not recall whether I documented those observations, but I may not have had time to record them.'

72. RN E stated that she asked the caregiving staff to continue to monitor Mr C and requested a dipstick urine test, and she asked the caregivers to continue to provide cares for Mr C in bed. She said that she asked the caregivers to put 'lip swab' on Mr C's lips because they were very dry, and she told them to elevate him and to ensure that there was a glass of water with a straw beside his bed because he appeared to be dehydrated.

73. A communication diary entry by RN E requested that HCA H obtain a urine sample and do a dipstick test and noted that the GP would be coming to review Mr C at 12.15pm.

74. At 8.57am the GP clinic emailed a request that Mr C's enrolment forms be provided. RN E told HDC that Mr C's enrolment forms were sent that morning at 9.19am, to ensure that the documentation was completed before the GP visit. RN E also completed a form requesting that the medical records be transferred from Mr C's previous GP to the GP on this date.

75. RN E told HDC that she did not consider contacting Mr C's family at this time, as she was not given information about the process for this at Kingswood (as outlined above) and, in addition, she was waiting for the appointment with the GP at 12.15pm. She said that Mr C had deteriorated markedly since the previous day, but she was reassured that the GP had been called and would be attending within a few hours to provide advice and direction.

76. When the GP reviewed Mr C, he assessed him as being acutely unwell with a suspected lower respiratory tract infection requiring urgent transfer to hospital for further care. The GP's medical notes discuss Mr C's presentation and comment on his rapid deterioration with confusion, bilateral crepitus (crackles in both lungs), a productive cough, cold hands and feet, and an oxygen saturation level of 75% (normal is over 95%). The GP documented that Mr C was afebrile (not feverish).

77. Mr G stated that when he began his shift at 1pm he was told that they were waiting for an ambulance for Mr C. Mr G said that he was surprised that Mr C was still unwell and stated that he had expected RN E to review him on 4 Month2 2019.

78. The ambulance service records indicate that the ambulance arrived on site at 2.10pm. Under 'history', the records note:

> 'Last week mobilising and eating normally but last [two days] has not been eating and been coughing. Last night increased productive cough and increased [shortness of breath].'

79. The vital signs recorded at 2.23pm by ambulance personnel included a temperature of 37.5°C,[13] although on repeating this at 2.46pm, which was after the ambulance is recorded as having left the facility, Mr C's temperature was 38°C, indicating a fever.

[13] According to Te Tāhū Hauora's Frailty Care Guidelines, a fever is a single temperature greater than 37.8°C, or greater than 37.2°C on repeated occasions.

80. Mr C's family told HDC that they are concerned that Mr C was transferred to hospital in a singlet and trackpants with no shoes, despite having pneumonia.

81. HCA H acknowledged that this is how Mr C left their care. HCA H said that they had removed his clothing to bring down his temperature while using damp cloths, and the GP was aware of this. Mr G said that he and the other two caregivers assisted the ambulance officers to transfer Mr C by placing him on the gurney in the same garments as he had been wearing in bed. Mr G said that they offered Mr C a blanket, but he turned it down as he was feeling hot.

82. Mr C's family were not contacted about his transfer to the public hospital. Mr B told HDC that they had no opportunity to visit him or speak with the doctor.

83. RN E recalled that this was a particularly busy day, and she had been unable to have a lunch break. She said that in addition to attending to the three units, she had a palliative resident requiring regular checks, GP visits, and another resident who was to be discharged and the requested paperwork had to be sent on to the new facility. She stated that when the GP came in and referred Mr C to hospital, she called the ambulance and arranged the paperwork and then did the handover, before returning to do the urgent paperwork that needed to be sent out that day. She said that after the ambulance left, she was preoccupied with other matters. She does not recall where Ms D was at the time or why she did not inform Ms D and said that she 'totally forgot' to call the family.

84. RN E stated: 'I appreciate that it was a terrible way for the family to find out … It's not an excuse to say that I was so busy, but that's what happened. I accepted that it was my fault.'

85. The only progress notes entry for this date was at 10pm, when an unknown staff member documented: '[T]ransfer to the hospital, no clothes given as he was too hot. Asked RN why he was not seen earlier. No reason except she is busy.'

Public hospital

86. The public hospital records state that Mr C was brought to hospital by ambulance with a reduced level of consciousness, shortness of breath, and a fever. He was diagnosed with severe bilateral bronchopneumonia.

87. Mr C's family said that they had no knowledge of his illness until they were contacted by the public hospital staff to inform them that Mr C had double pneumonia and was dying. Mr C's condition and prognosis were discussed with his family, who were told that further aggressive treatment was likely to be futile. It was explained that his comfort would be the focus of his care.

88. Mr C's family accepted the plan, and comfort cares and medications for symptom relief were provided. Sadly, Mr C died, in the presence of his family.

Subsequent events and complaint management

89. Mr C's family were concerned that, as at the time of making their complaint, there had been no formal response from Ms D to the events, despite the family's request for an investigation and review. They also had not received any formal confirmation of how Mr C's illness had progressed.

8 Month2 2019

90. Mr B said that he was contacted by a nurse from Kingswood on 8 Month2 2019. He said that she expressed her condolences and apologised, telling him that she had been instructed not to contact the doctor with her concerns about Mr C's deteriorating condition on 4 and 5 Month2 2019.

91. RN E said that she did not make that call and she was not on duty that day, and did not tell Mr B (or other Kingswood staff members) that she was told not to contact the doctor by Ms D. It is unclear who contacted Mr B on this date. There is no documentation of this call.

92. Mr B said that he then contacted Ms D directly. He stated that Ms D called him back after 20 minutes and told him that it had been 'taken care of', as the nurse who had telephoned him had been dismissed.

93. Mr G told HDC that he was the one who informed the family that the nurse had been dismissed, 'but the nurse had already resigned' and 'it was brought forward to the 13 Month2 2019 as a result of her lack of professionalism and short comings on the day in question'. It is unclear when Mr G contacted the family, but it appears to have occurred at a later date.

94. In response to the provisional opinion, Kingswood stated that they are very sorry that their response came across as uncaring.

12–13 Month2 2019

95. Ms D told HDC that she returned from leave on 12 Month2 2019 and met with RN E and EN F for a handover. EN F had also been absent and returned that day. Ms D said that she was informed that Mr C had been admitted to the public hospital and they had not heard from his family, so she asked EN F to contact the hospital.

96. At 1.45pm on 12 Month2 2019, EN F documented that they had just been informed that Mr C had passed away. There is no other documentation of communication with the public hospital since Mr C's transfer on 6 Month2 2019.

97. There is no documentation of contact with the family on this date. EN F said that the call with the hospital occurred 'late in the evening' (although this is not consistent with her documented note) so she informed Ms D and they decided to look into it the following day.

98. Ms D also said that as it was so late in the day, she decided to contact Mr B the following morning, but he rang on 13 Month2 2019 before she did so. The 'family discussion notes'

record that Mr B reported that there had been no notification from the registered nurse regarding his father's transfer to hospital.

99. EN F said that she took this call, and Mr B told her that he was wanting confirmation from Ms D that in future all families would be notified of hospital transfers. Ms D said that this was the first time they were made aware that the family had not been contacted at all.

100. EN F created an incident report dated 13 Month2 2019. The incident report stated: 'Received a call from [Mr B] wanting to talk to [Ms D] about how [Mr C's] medical needs were attended to and lack of communication …' Under 'main factors that contributed to this incident', EN F documented: '[RN E's] incompetence & lack of communication.'

101. The next entry in the 'family discussion' notes on 13 Month2 2019 indicates that Mr B returned Ms D's call and asked her to accept responsibility for the registered nurse's actions and make sure this would not happen again, which she says she did.

102. RN E also spoke to Mr B on 13 Month2 2019, after being called by Ms D advising her that the family had concerns. RN E recalled that Ms D told her to call Mr B and said that if they made a complaint, '[she would be] on her own'. RN E said that she spoke to the family and sincerely asked for forgiveness for not informing them what happened to their father and that he had been sent to the hospital.

103. In a letter dated 13 Month2 2019, Kingswood wrote to RN E:

> 'I was informed by [Ms D], yesterday that you have resigned …
>
> I have now just been informed of a very serious incident — that you didn't advise a family that a resident, [Mr C], was taken to hospital and that that resident passed away at the hospital without the family being informed that he was even there.
>
> In all the years that we have been operating rest homes, I have never heard of such a thing and we are now left facing this family and fall-out from this will be enormous. You have not carried out your duties and have not acted and dealt with us, your employer and our clients, the residents and their families, in good faith. You had a responsibility not to act against the trust and confidence which we had with you and you have not acted reasonably or done your work with the care required of someone in your position.
>
> As a result of this incident we are hereby giving you notice that you are suspended with immediate effect and that you will not be required to work out your notice period …'

Telephone call with Mrs A — on or around 24 Month2 2019[14]

104. Mr B said that he asked his sister, Mrs A, to follow up with Ms D. In response to the provisional opinion, Mrs A told HDC that she contacted Ms D on the morning of 22 Month2

[14] In response to the provisional opinion, Kingswood told HDC that this call occurred on 22 Month2 2019.

2019 and left a message, but did not hear back from her. By lunchtime on 24 Month2 2019, she still had not heard from her, so she telephoned Ms D again. Ms D told Mrs A that she would investigate and send a written report the following day, but Mrs A said that nothing was received. Mrs A stated that she found Ms D's manner disrespectful and dismissive.

105. An undated entry in the 'family discussion note' states:

> '[Mrs A] has rung. Still understandably very unhappy with [what] has happened with her late father's transfer to hospital. [Mrs A] would rather deal with [Mr G] who assisted the RN in my absence while I was on leave at the same time all this occurred. [RN] apparently have told the family she has been fired over this incident. This is not the case [Kingswood] brought her 2 weeks resignation closer and paid her out.'

106. Mr G told HDC that this call occurred on 24 Month2 2019 and he was present with Ms D, and two other staff members.

107. Mrs A said that when the conversation ended, as Ms D did not disconnect the call, she overheard Ms D insulting Mr C's family, instructing staff not to communicate with them, and asking them to fabricate notes detailing that they had attempted to contact the family earlier.

108. Ms D has not commented on this. Mr G said that the comments overheard were in relation to the registered nurse and not [Mr C's] family.

25–29 Month2 2019

109. On 25 Month2 2019, Mr G documented that he made contact with Mr B to return Mr C's belongings and discuss events. Mr G told HDC that he was asked by Ms D and [Mr C's] family to be a 'mediator and investigate the shortcomings of the unfortunate passing of the late [Mr C]'. Mr G said that he contacted the family after Ms D 'had tried repeatedly to no avail in consoling the family and expressing what had happened in her absence'.

110. Mr G said that they arranged to meet in person, and he met with Mr B the next day, on 26 Month2 2019.

111. Mr G documented in the family discussion notes (dated 25 Month2 2019) that they arranged to meet in person, and when they met, they discussed the issues surrounding Mr C's passing. Mr G recorded that he explained that the registered nurse had resigned, and he discussed the 'misunderstanding of the overheard conversation' by Mrs A after the phone was not hung up correctly. He documented that he 'expressed sincerely that it was not [Mrs A they] were calling names but the RN who had mishandled the whole situation'. Mr B reportedly expressed that he wished that the manager would take responsibility for it all, and Mr G said that he would arrange for her to put in writing what they would do to prevent such an incident in future.

112. Mr G said that he also called Mrs A to ask what they could do and apologised and reassured her that the swearing and name calling was about the nurse, and at no time were they implicating such things about her or her family.

113. On 29 Month2 2019 Ms D sent a letter of apology to Mr C's family, which stated:

> 'I'm writing to apologise for the way in which your late husband/father, [Mr C's] transfer to the [public hospital] from Kingswood Healthcare Morrinsville was handled during my leave. I had handed over to our Registered Nurse, as is procedure, to carry out senior responsibilities while I was on leave and she did not step up to the responsibility very well.
>
> I as the manager take full responsibility for [this] and can promise that nothing like this will ever happen to another resident or a family who have a loved one in our care.
>
> As you know immediate steps were taken and a full investigation has been carried out as to why this happened at all.
>
> We can never make up for this, I realise, but I want to assure you that this is not our modus operandi. We at Kingswood … pride ourselves on the way we care for our residents and how we interact with their families and what happened during the process of transferring [your] husband/dad to hospital should never, ever have happened and will not ever happen again. We have always had policies and procedures in place for what steps happen in every scenario of care and these rules were simply ignored by the RN.'

114. It appears that this was drafted by a senior staff member of Kingswood Healthcare Morrinsville Limited and sent to Ms D, who forwarded it to the administrator, requesting: 'Please read this to [Mr G] is this what they want [redacted?]'

115. There appears to have been no further documented action taken or communication provided to Mr C's family after 29 Month2 2019 in response to the complaint, including the provision of a formal response as requested.

Kingswood internal review

116. Ms D asked RN I, a senior staff member at Kingswood, to complete an internal investigation regarding these events. RN I told HDC that upon finishing the investigation, she found many faults with the handling of Mr C's care, which she reported to Ms D, but at that time Mr C's family were wanting only an apology. RN I said that when the HDC complaint was received, she 'began to investigate this again'.

117. Neither of these internal investigation reports have been provided to HDC.

118. RN I told HDC in a letter dated 15 July 2020 (in response to HDC's request for information) that she found that RN E had not practised in a safe manner and had not followed Kingswood policy and procedures regarding contacting GPs, ambulances, and family. RN I's

letter to HDC outlined her investigation findings (see Appendix C, but HDC did not receive the original internal investigation reports). RN I stated:

> 'In my clinical opinion I believe that [RN E] acted negligently, she failed to provide the appropriate care and escalation that [Mr C] needed. I feel sorry for Kingswood rest home as the policy and procedures are clearly laid out and easily accessible to all staff, they are in all units and can be printed out if needed to have a personal copy. I also believe [RN E] failed to accurately document any observations or assessments of [Mr C].
>
> …
>
> I believe that [RN E] and only [RN E] is responsible for [Mr C's] untimely death. Should she have escalated this earlier I believe there may have been a better chance of survival.'

119. RN E told HDC that she was not contacted by RN I, so she did not have an opportunity to participate in the review. Kingswood said that RN I did contact RN E but was unable to find the correspondence relating to this.

Incident reports provided to HDC

120. Kingswood provided the following incident reports and statements to HDC:[15]

a) On 15 July 2020, HCA O wrote a statement in relation to Mr B's complaint. HCA O stated: '[RN E was] on call in the weekend. She stated to me that she would not come into work when called, she would even ignore the phone and not answer. Her reason was that she did not get paid to come in. I stated that she needs to be available for the residents and she said not my problem.' It is unclear what dates this refers to or whether this was directly in relation to Mr C's care.

b) An incident report by EN F dated 13 Month2 2020 stating: 'Had telephone meeting with [Ms D], [RN E] & myself regarding this incident. She told us [Ms D] told her not to call doctor, not true as [Ms D] was on leave, told us she contacted family when sending to [the public hospital]. No documentation of such discussion. Told us she was busy with [another resident] who had already left & [caregiver] should've called family.' There is no reference to Mr C on this incident report.

c) An incident report by HCA H dated 18 Month2 2020 outlining his recollection of the events of 4 Month2 2019 (see paragraph 52 above).

d) An incident report by Ms J dated 20 Month2 2020 stating: 'Requested from … [RN I] to write an incident report regarding to have never been asked by [RN E] for assistance while the general manager [Ms D] was on leave. At no time did the RN ask for assistance nor the [site] manager at any given time.'

[15] HDC was unable to contact HCA M and HCA N, whose statements were specifically requested.

121. RN E said that she became aware that some staff at Kingswood had written incident reports only when preparing her statements for HDC. She noted that they were not written until more than one year after Mr C's death, and that these made inaccurate comments about her care of Mr C. She said that she does not agree with the contents of those reports, nor was she asked for her side of the story.

122. In response to the provisional opinion, RN E stated that she 'does not accept any of Kingswood's unfounded allegations or accusations against her as recorded in the documents supplied to [HDC]'. She stated that 'none of these matters' were put to her during the course of her employment.

Further information: RN E

123. RN E expressed her sincere condolences to the family for the loss of Mr C, and she apologised that she did not communicate with them that he was unwell that morning and that he had been taken to the hospital.

124. RN E told HDC that she was under a lot of stress when she worked at Kingswood, and she became anxious about going to work because of the huge workload and the inappropriate requests made by Ms D. RN E said that when she started working at Kingswood there was a significant backlog of incomplete paperwork, including care plans that needed to be updated for each resident.[16] These documents were out of date because prior to her starting in the role, there had not been a registered nurse employed at Kingswood for several months. She stated that when she first looked at the documents, she noticed that the content of all the care plans was identical, and only the name of the resident had been changed, so the plans were not personalised in any way. She said that it took her a long time to work through the plans and update them so that they were specific to each resident.

125. RN E said that she was also very busy with training to be an interRAI assessor, which Ms D was 'rushing' her to complete as soon as possible so that she could complete interRAI assessments independently and without sign-off from her tutor.

126. RN E said that she also had a lot of day-to-day tasks that needed to be completed on an ongoing basis. These included nursing and clinical care of residents, arranging GP consultations and other bookings, documentation for hospital reports, overseeing medication, and checking paperwork. She said that she worked five days a week, and there was never enough time to complete all the work that needed to be done.

127. RN E told HDC that caregiving staff gave handovers to one another at the shift changeover, but she did not receive a verbal handover from anyone when she began work in the morning. She said that when she started her shift at Kingswood each day, she would review the communication diary and visit each of the three units at the facility, and she would ask the caregivers in each unit how the residents were and whether there were any

[16] In response to the provisional opinion, Kingswood disputed that there was a 'significant backlog'.

matters of concern. She noted that this practice is different from her current role, where nurses receive a verbal handover from the previous shift.

128. RN E stated that she could call the registered nurse at the first care home if she had questions, but that nurse was inexperienced herself (she had been practising for only one year),[17] and she was unfamiliar with the Morrinsville facility and its residents. RN E said that as a result, if she had questions, she tended to ask either the district nurse or the palliative care nurse who came into Kingswood.

129. RN E stated:

> 'As a newly registered RN, I accept that I was not fully aware of everything that was required to be done in the facility. I didn't have a senior RN to work with, and although I could call the RN [at] [the first care home], it was not the same as having the one you have in person.'

130. RN E noted that often Ms D gave directions to the caregivers and the enrolled nurse without involving her, which meant that she was not always aware of what decisions had been made or what was happening. For example, Ms D once told a caregiver not to give a resident her full medication, but RN E was not told the reason for this.

131. RN E said that she resigned on 12 Month2 2019 prior to being made aware of Mr C's family's concerns, as she did not feel 'safe' working at Kingswood.

Further information — Kingswood

132. Ms D provided the staff rosters for 28 Month1 to 10 Month2 2019. She said that extra staffing was available should it have been needed, and RN E could have called for extra help at any time. Ms D stated that Kingswood staffing levels exceeded the requirements of the ARRC (Age-Related Residential Care Contract).[18] RN I also said that the enrolled nurse could have been contacted to come to Kingswood to help.

133. In response to the provisional opinion, Kingswood also stated that since it opened its care home in Morrinsville in 2016 it had never had more than one registered nurse employed at that site and previous nurses did not have any issues with workload. It noted that since 2022, it is now certified to cover hospital and psychogeriatric care, which requires 24/7 registered nurse cover, and it now employs six registered nurses and one enrolled nurse.

134. Kingswood told HDC:

> 'I would like to add that Kingswood feels that the Kingswood RN is the one who needs to accept responsibility for the failings in this case. Since we have implemented many things since this has happened nothing like this has happened again.'

[17] In response to the provisional opinion, Kingswood stated that the first care home registered nurse had a few years of nursing experience.

[18] The ARRC agreement is a national contract between health funders and providers of residential care services.

135. Kingswood advised that it accepted the shortcomings in the lack of communication with Mr C's family and said that it has made relevant changes.

Responses to provisional opinion

Mrs A

136. Mrs A was given an opportunity to respond to the 'information gathered' section of the provisional opinion. She stated:

> 'The total lack of care and professionalism — there are many conflicting statements such as whether Dad had a temperature. Just seems like total chaos … In conclusion to what I am hoping is the last correspondence on this very sad matter after 4 years. I would like to leave you with the thought that we have had to live with, the fact that Dad was sick and did not receive the appropriate care. It was 4 days before he received treatment whilst all the while dying from neglect. He suffered in those last days at the hands of Kingswood in a place where his Family had placed their trust only to be betrayed.'

Kingswood Healthcare Morrinsville Limited

137. Kingswood was given an opportunity to respond to the provisional opinion. Kingswood's response has been incorporated into the report where relevant.

138. Kingswood said that it cares deeply about the services it delivers, and what happened 'should never, ever have happened'. Kingswood stated: '[W]e are so sorry that [Mr C's] family had to say goodbye to their father like this, having entrusted him in our care.'

RN E

139. RN E was given an opportunity to respond to relevant sections of the provisional opinion. Her response has been incorporated into the report where relevant.

Ms D

140. Ms D was given an opportunity to respond to relevant sections of the provisional opinion, and she provided a response.

The first care home

141. The first care home was given an opportunity to respond to relevant sections of the provisional opinion, and it provided a response.

Opinion: Introduction

142. I acknowledge the family's distress as a result of the days prior to Mr C's death, particularly as they had not been informed that his condition had deteriorated or that he had been transferred to the public hospital. In addition, I appreciate the patience of Mr C's family

throughout the HDC investigation, which has been impeded by the length of time it has taken for Kingswood to respond to requests for information.

143. At the time of events, the New Zealand Health and Disability Services (General) Standard (NZS 8134.0:2008)[19] required aged-care facilities to ensure that the operation of their services was managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.

144. The New Zealand Health and Disability (Core) Standards (NZS 8134.1:2008) also include:

> 'a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;
>
> b) Consumers receive timely services, which are planned, coordinated, and delivered in an appropriate manner;'

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

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

Opinion: Kingswood Healthcare Morrinsville Limited (trading as Kingswood Rest Home) — breach

146. Kingswood had overall responsibility to ensure that Mr C received care that was of an appropriate standard and that complied with the NZHDSS and the Code of Health and Disability Services Consumers' Rights (the Code), and this included responsibility for the actions of its staff.

147. In my view, there were deficiencies in the care provided to Mr C by staff at Kingswood, and these were systemic issues for which Kingswood Healthcare Morrinsville Limited bears responsibility.

Admission to Kingswood

148. Mr C transferred from the first care home to Kingswood on 29 Month1 2019. Kingswood's manual and policies specify its admission expectations and service provider

[19] The updated Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 came into effect on 28 February 2022.

responsibilities, in line with the ARRC service agreement. Ms D was responsible for the coordination of safe resident admissions, in partnership with RN L.

149. The manual outlines the admission day responsibilities and refers to the use of an admission checklist for the admitting team to follow. There is a registered nurse task list to assist the admission process, which provides instructions regarding completion of admission documents, setting up of clinical files, care home lists, nursing assessments, and care plans. These steps are also reflected in the registered nurse orientation book. The enrolment forms for the medical practice and pharmacy are required to be completed on the day of admission and a GP visit scheduled within two working days, to admit the new resident medically.

150. My in-house clinical advisor, RN Jane Ferreira, advised that these processes were in line with accepted practice. However, they were not complied with, as outlined below.

151. RN Ferreira advised that RN E's entry does not introduce Mr C as a new resident or discuss his care and safety needs, which would be considered an accepted part of the admission nursing process. She also noted that there is no evidence that admission nursing assessments such as falls risk, pain or skin assessments were completed, or that Mr C's weight and baseline observations were recorded. As noted above, in response to the provisional opinion, Kingswood provided a handwritten note outlining the admission process, but RN E stated that this was not in her handwriting.

152. RN Ferreira said that the usual practice for residents living with a diagnosis of dementia mate wareware who are transitioning to a new environment would be to commence a behaviour monitoring plan, supported by a specific nursing plan to outline individualised care and safety needs. She stated that as Mr C was known to the organisation and was transferring between care homes, it would be accepted practice for a coordinated plan to be in place, facilitated by RN L, to ensure that the receiving care team were aware of Mr C's care and safety needs while he was settling into his new home. A behaviour monitoring plan and a coordinated plan facilitated by RN L do not appear to have been developed, although Kingswood has more recently provided a copy of a short-term care plan prepared by the enrolled nurse at the first care home.

153. RN Ferreira also noted that there was no communication with Mr C's EPOA, Mr B, to inform him of Mr C's arrival at Kingswood or to involve Mr C's whānau in the admission process, which would be accepted practice.

154. Residents were required to have a health and personal assessment completed on or within 72 hours of admission, and a lifestyle care plan completed within three weeks of admission. RN Ferreira stated that this process aligns with service provider responsibilities. There does not appear to have been a health and personal assessment completed during 29 Month1 to 1 Month2 2019.

155. RN Ferreira also noted that the admitting nurse, RN E, was responsible for informing the medical practice and pharmacy and completing the relevant enrolment forms on the day

of admission, but the enrolment documentation for the medical practice was completed only on 6 Month2 2019, and this was also the date on which Mr C was first seen by the GP, which is outside the ARRC contractual requirements. I note that RN E had stated that she was advised during her orientation that a resident needed to be enrolled with the GP and seen within the first week of admission, and in response to the provisional opinion, Kingswood confirmed this, although this is contrary to Kingswood's own manual. Regardless, Mr C was not enrolled or seen by the GP until his ninth day of admission.

156. RN Ferreira said that it is unclear why this process was delayed and stated:

> 'Given [Mr C] was known to [RN L] and [the] RN team it is unclear why this process was not facilitated by the organisation's clinical or general manager prior to his transfer to the new care home, in line with their role responsibilities to lead and direct safe resident admissions.'

157. As outlined above in paragraph 20, Kingswood told HDC that Mr C was seen by the GP the day before his transfer. However, Kingswood has not provided HDC with any evidence of this.

158. I accept RN Ferreira's advice and consider that the admission process for Mr C was inadequate.

Handover processes at Kingswood

159. RN Ferreira noted that the registered nurse orientation book provides an outline of shift handover processes, which includes reviewing the communication book, visits to all units to receive a verbal update from duty teams, visual checks of all residents, and essential document review. The registered nurse task list refers to receiving handover from the previous shift and outlines shift responsibilities. The information states that 'if residents are sick, look for infections and pain, contact GP if needed'.

160. However, RN Ferreira noted that there is no reference to types of assessments, decision-making tools, or use of on-call senior nurse support, which would be valuable resources for a junior registered nurse. She stated that the document refers to the use of a care home diary, communication book, and handover sheets, which outline carer responsibilities, but there is limited information about teamwork, leadership responsibilities, and direction and delegation of resident care.

161. RN Ferreira advised that it is unclear what process was followed for introducing new residents to the care team in verbal and written form across the different shifts, to discuss the new resident's care and safety requirements. She said that as Mr C was known to the organisation and had transferred between the care homes with an established nursing care plan, recommended practice would have been for RN L to provide orientation, care oversight, and guidance to the junior registered nurse and care team during Mr C's settling-in phase. However, there is no evidence of care leadership by RN L or related organisational oversight of the transfer process to suggest that these responsibilities occurred.

162. I accept RN Ferreira's advice. In my view, the handover process and information provided to the registered nurse and care team were insufficient for Mr C to be provided with adequate care.

Standard of care and documentation during Mr C's admission

163. RN Ferreira advised that the care team's role is to deliver care in partnership with the registered nurse, resident, and family/whānau, and to document actions and report their findings or concerns to the registered nurse or clinical lead. She said that it is usual practice for care-home teams to ensure that newly admitted residents are monitored and supported closely during the settling-in phase.

164. RN Ferreira noted the following:

a) On 2 Month2 Mr C was noted to have had reduced oral intake and a sleepy presentation, and on 3 Month2 a caregiver noted that he had a swollen right foot and was asleep by 7.30pm. The progress notes do not discuss reports of pain or reduced mobility, signs of breathlessness, or concerns about oral intake or elimination patterns observed by the care team. It is unclear whether senior caregivers recorded Mr C's vital signs at this time to inform the nursing assessment, which would be considered appropriate in the circumstances.

b) The diary note on 3 Month2 2019 (concerning mucous in Mr C's right eye, and Mr C sleeping a lot and appearing uncomfortable) had no corresponding entry in the progress notes to describe the signs of eye redness or discharge, or that concerns had been reported to the on-duty or on-call registered nurse. I note that to the contrary, the progress notes on this date indicate that Mr C was well and there were no concerns, except for at 11pm when it was noted that he had a swollen foot and had gone to sleep at 7.30pm. RN Ferreira noted that the swollen foot does not appear to have been diarised for registered nurse assessment, and there is no evidence of any registered nurse actions in response to communication prompts when receiving handover, in line with shift guidance.

c) On 4 Month2, when Mr C was documented as restless and having refused dinner, and in bed by 5pm, it is unclear whether alternative dietary options were considered, or supportive interventions offered by the senior caregivers. There is no evidence that any preliminary assessment occurred at this time, or if concerns were handed over to the next shift.

d) On 5 Month2, there is no evidence to indicate that the caregivers escalated concerns to the on-duty or on-call registered nurse for support (in relation to the vomiting episode, being in bed all day, and taking only fluids across the shift), or that any nursing assessment occurred at this time. Accepted practice would be to record vital signs, compare data to Mr C's baseline admission recordings, assess pain, hydration status, oral intake, and elimination patterns, and escalate concerns to the GP for further guidance. There are no further entries in the progress notes by qualified or care staff at this time, nor evidence of any completed monitoring forms to inform additional comment.

165. RN Ferreira advised that from the clinical information reviewed, it is unclear whether the care home team recognised signs of Mr C's health decline. She noted that Kingswood's response does not discuss contributing factors to the delay in recognising and acting on Mr C's observed health changes by the care home team at the time.

166. I agree. In addition, I note the following deficiencies in documentation:

a) Mr C was a high falls risk and noted to require regular safety checks. There are no references to these checks in the clinical notes.

b) There initially appeared to be no references throughout his entire admission in relation to medication administration or evidence of a medication chart. In response to the provisional opinion, Kingswood provided a medication signing sheet of medication administration by both care homes for 7 Month1 to 2 Month2 2019. This had not been provided to HDC in response to previous information requests. This appears to confirm that his regular medications were provided at breakfast, lunch, and dinner. However, there is not a chart of Mr C's last three days at Kingswood (4–6 Month2 2019).

c) There are no entries in the progress notes by the caregivers on 30 and 31 Month1 2019 (Wednesday and Thursday).

d) There are no records for 30 and 31 Month1 2019 in the 'behaviour chart'. The chart was not completed for every shift on these dates.

e) There are no records on 4 Month2 2019 relating to concerns about Mr C's condition on this date (reported one year later to be 'coughing up mucus … eyes were weeping and also had a high temperature'). There is also no documentation of the reported escalation of these concerns to the registered nurse, or the instructions that were reportedly given, or that this was handed over to the next shift, although RN E disputes that this occurred and notes that the HCA's recollection appears more consistent with the events of 6 Month2 2019, not 4 Month2 2019.

f) There are no records of the review by the registered nurse and caregiver on 5 Month2 2019, which RN E said occurred, including details of the nursing assessment, any observations, details of instructions given to the caregivers, or evidence that these instructions were carried out.

g) There is no documentation of RN E's or any other staff member's review of Mr C on 6 Month2 2019, nor details of the instructions given to caregiving staff or evidence of these having been carried out.

167. I am concerned that on the information available to me, it appears that the care provided to Mr C was not consistent, and the documentation, handover, and escalation of concerns when identified was not adequate, and there is a lack of evidence of any appropriate responses to concerns.

Communication with Mr C's family

168. The NZS 8134.0.2008 states that family/whānau of choice are to be involved in the planning, implementation, and evaluation of the service to ensure that services are responsive to the needs of individuals, and the ARRC Services Agreement requires service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in the resident's health condition or of any adverse event.

169. There is no record of interaction between Mr B and Kingswood during the admission process or at any point during Mr C's admission. Kingswood pointed to Mr B being advised of the transfer five days prior to admission, and the nursing note on the day of admission that the family had been informed, but both these entries were by staff of the first care home.

170. Mr C's family/whānau were not informed about his health concerns, GP assessment, or his transfer to hospital while at Kingswood. RN E has acknowledged that the family were not contacted. RN Ferreira advised that this would be considered below accepted clinical practice standards and service provider responsibilities.

171. Mr B was Mr C's EPOA and, as such, he had the right to be informed about Mr C's illness and to give informed consent to any proposed changes to Mr C's care. RN Ferreira stated that care decisions are made in partnership with the EPOA, and registered nurses are required to document these interactions in the resident's family/whānau contact record, care plan, progress notes, and any relevant meeting minutes. She said that the lack of communication affected Mr C's right to have a support person present at Kingswood and on his admission to the public hospital.

172. RN Ferreira advised:

> 'Evidence of communication with a resident's nominated representative is an essential part of service provider responsibilities and a fundamental element in the nursing process. The apparent lack of communication between the care home team and [Mr C's] EPOA, and lack of related documentation would be considered a serious departure from the accepted standard of practice.'

173. RN Ferreira also stated: 'Having a support person present is of significant importance when caring for an unwell resident living with a diagnosis of dementia mate wareware, particularly in an unfamiliar environment.' She advised that the communication between Kingswood and Mr C's whānau was below the accepted standard of practice.

174. I agree. I note Mr B's comments that they had no opportunity to visit Mr C or speak with the doctor, and it is concerning to me that Mr C's EPOA and Mr C's family were deprived of the opportunity to assist with Mr C's admission, particularly as Mr C was a vulnerable consumer with a diagnosis of dementia mate wareware and was in a new and unfamiliar environment, and the reason for his admission was unclear. I am also very critical that Mr

C's EPOA and Mr C's family found out only from the public hospital that Mr C had been unwell and had been taken to hospital.

Transfer to public hospital

175. As outlined above, Mr C was transferred to the public hospital on 6 Month2 2019. However, there is nothing in Kingswood's clinical records to indicate how and at what time he was transferred, nor any communication with Mr C's family prior to or after transfer to hospital.

176. Kingswood's internal procedure outlined that residents must be physically prepared, including dressed appropriately, prior to leaving the facility. Mr C's family were also concerned that he was taken to hospital in a singlet and trackpants with no shoes.

177. Kingswood staff acknowledged that this was how Mr C left the facility. Kingswood staff indicated that the reason for his limited clothing was their attempt to bring down his fever. However, I note that this is at odds with the GP's assessment that Mr C was afebrile (as at approximately 12.15pm), and the ambulance records indicate that he had a normal temperature prior to the ambulance leaving the facility at 2.39pm.

178. RN Ferreira advised that there is no evidence in Mr C's clinical file that organisational steps were undertaken with respect to resident transfers, and she considered this a serious departure from accepted practice.

179. I agree. Indeed, if looking only at the written documentation from the care home on 6 Month2, it is not at all evident how unwell Mr C was or his reason for transfer. It is only through documentation by the GP and the ambulance service that I am aware of this information and the time of Mr C's transfer.

180. In my view, Mr C was not dressed appropriately for his transfer, as outlined above, and the lack of communication with Mr C's family is concerning. In the circumstances, I consider that Kingswood staff did not prepare Mr C for transfer adequately.

Complaint and incident management

181. Once Mr C's family raised concerns with Kingswood about the care provided to Mr C, there does not appear to have been any clear process followed to address these concerns.

182. Mr B said that he was contacted by a nurse on 8 Month2 2019, and then he contacted Ms D about his concerns. It is unclear who contacted Mr B on this date and there is no documentation of either of these calls. The next contact appears to have been on 13 Month2 2019, when Mr B contacted Kingswood to discuss his concerns. RN E was made aware of the concerns on this date, and she called Mr B to apologise.

183. There was no further contact until Mrs A telephoned Ms D on or around 24 Month2 2019, and it appears that there was a breakdown in their relationship during this call. Senior caregiver Mr G appears to have taken over as the intermediary between Mr C's family and

Kingswood, and he contacted Mr B on 25 Month2 and met with him the following day, to return Mr C's belongings and discuss events.

184. An apology was sent by Ms D on 29 Month2 2019, but this did not provide any details of how Mr C's illness had progressed, or any outcome of a review or findings of the 'full investigation' stated to have been carried out. Following this, there appears to be no further documented action taken or communication provided to Mr C's family in response to the complaint, including provision of an investigation and review as requested, or confirmation of how Mr C's illness had progressed.

185. RN Ferreira noted that according to Kingswood policies, the manager is responsible for ensuring that the complaints process is adhered to at all times, and that all complaints are dealt with in writing to ensure a positive outcome. She noted that Kingswood submitted event information that includes a complaint response, but it is unclear whether Mr C's whānau were invited to meet with the provider in line with the organisation's policy and accepted practice standards. RN Ferreira advised that there appear to be opportunities for improvement with complaint management processes and documentation standards to reflect family/whānau involvement in meaningful, consumer-focused service delivery, and to ensure that services meet the appropriate standard.

186. In my view, Kingswood's management of the complaint made by Mr C's family, and the information provided to them, was inadequate. Most of the contact that occurred was prompted by Mr C's family making contact first. There is no evidence that Kingswood completed a review to answer Mr C's family's queries about their father's care, or provided details of its investigation, other than a written apology. There is no evidence of Kingswood having advised them of their right to access advocacy services or to complain to HDC. In my opinion, the communication that occurred in relation to Mr C's family's concerns did not instill confidence that appropriate changes had been made or that learning had been taken from this incident.

187. I note also that it appears that no full investigation was undertaken despite Kingswood's submissions that this was done. There is no separate investigation findings report, nor any evidence that any investigation findings were provided to any of the parties involved. The only evidence of this was a letter to HDC provided by Kingswood approximately eight months after the events, in response to HDC's request for information, outlining the reported investigation findings — ie, there is no evidence that an investigation was done at the time of the events. I note that the findings focused almost solely on the service provided by RN E and did not identify any other issues, such as those I have outlined above.

188. Several incident reports were also provided that were created at least seven months after the events, and some over 12 months later. I note that RN I's internal investigation letter indicated that she requested that these be completed at the time of her investigation.

189. RN Ferreira noted that it is unclear from the provider's response why there were issues in applying the organisational processes to practice during the timeframe in question. She

noted that the provider response (to HDC) has discussed factors that may have contributed to Mr C's decline, but the provider has not provided evidence of a corrective action plan in response to learning from this complaint. She noted that there is evidence that organisational policies have been reviewed and updated to reflect provider responsibilities to contact families and access on-call support, but opportunities remain for the care-home team to review policies and processes regarding resident admissions and related responsibilities for nursing assessment and care planning, teamwork, open communication, and informed consent.

190. RN Ferreira considered that Kingswood's organisational policies and procedures were adequate at the time of Mr C's admission, but she identified areas regarding staff training, leadership, complaint management, communication, and documentation standards that were a moderate to significant departure from accepted standards.

191. I accept this advice. In my view, it does not appear that Kingswood investigated the care provided to Mr C appropriately and took learning from this, other than identifying deficiencies in RN E's care. This meant that wider learning by the care team did not occur, and I agree that opportunities remain for the care-home team to review relevant policies and processes further.

Conclusion

192. With respect to the care provided to Mr C during his admission, including the admission process, shift handovers, documentation, and his transfer to hospital, RN Ferreira identified areas of concern regarding clinical leadership and oversight of nursing practice, completion of timely nursing assessments and care planning, recognition of resident decline, clinical decision-making, and care escalation, as well as departures from accepted standards regarding communication processes, teamwork, and documentation. She stated that these represented a significant departure from accepted practice.

193. I accept this advice. For the above reasons, I find that Kingswood Healthcare Morrinsville Limited failed to provide services to Mr C with reasonable care and skill and breached Right 4(1) of the Code.

194. As outlined above, there was a concerning lack of communication with Mr C's EPOA and family, particularly when Mr C was transferred to the public hospital. I consider that Kingswood Healthcare Morrinsville Limited failed to communicate effectively with Mr C's EPOA and family and, accordingly, breached Right 5 of the Code.

195. I also consider that Kingswood Healthcare Morrinsville Limited's response to Mr C's family's complaint was inadequate, and, as such, I find that it also breached Right 10 of the Code.

Opinion: Ms D — breach

196. Ms D was a senior staff member at the care home. Ms D had overall responsibility for the care provided to residents.

Ms D's role — other comment

197. Ms D said that she is not qualified as a registered nurse. I acknowledge that she is not clinically trained, but I note that RN L was situated at the first care home, and Ms D appears to have been extensively involved in the care provided to the Kingswood residents, including giving instructions to the caregivers about matters such as medication management (see paragraphs 36 and 130 above).

198. It also appears that staff were unclear about Ms D's role regarding clinical concerns. HCA H said that all the staff members were aware that they could contact Ms D at any time regarding the care of any resident and, in hindsight, that should have been done when Mr C became unwell. RN E said that Ms D decided who should contact family members regarding any issues with residents and recalled that Ms D often gave directions to the caregivers and the enrolled nurse without involving her, meaning that she was not always aware of what decisions had been made. In my view, it should have been clear to staff that clinical concerns should be raised with the registered nurse or Clinical Manager.

Ms D's responsibilities with respect to Mr C's care

Prior to admission

199. Ms D's role included responsibility for the day-to-day smooth running of the home at every level. That included to ensure that all residents were assessed prior to admission, that their needs could be met at the home, and that emergency admissions were assessed as soon as possible by a mental health service. Together with the registered nurse, Ms D was responsible for ensuring that this request was submitted on the next working day after admission. It is unclear whether Mr C's admission to Kingswood was an emergency admission, as the reason is not recorded clearly.[20]

200. Mr C's last interRAI assessment had been completed a few months prior to the transfer, with a continuing care plan in place, both from the first care home. Both documents provide discussion of Mr C's care requirements and agreed support at the time of assessment, but there is no evidence of care evaluation prior to his transfer on 29 Month1 2019, and no rationale for his change in care circumstances is recorded.

201. RN Ferreira advised that it is unclear why the interRAI assessment information was not updated in line with ARRC contractual responsibilities if Mr C required a change in care level, or whether NASC services were involved in Mr C's review and transfer of care process, as outlined in the ARRC. In response to the provisional opinion, Kingswood stated that there had been no change in level of care, as Mr C was receiving dementia-level care at the first care home.

[20] In response to the provisional opinion, Kingswood stated that it was not an emergency admission.

202. In my view, it remains that there was no evidence of care evaluation or evaluation of change in care circumstances prior to his transfer, and Ms D should have liaised with RN L to ensure that the interRAI assessment information was updated.

Admission to Kingswood

203. Ms D was responsible for the coordination of safe patient admissions, in partnership with RN L. Ms D was also required to ensure that all residents had a plan of care/support prepared by the registered nurse, and that each resident and/or their representatives had been involved in drawing up the care plans. Kingswood policies state that each resident will have a health and personal assessment completed on or within 72 hours of admission, which aligns to service provider responsibilities in the ARRC.

204. Mr C transferred from the first care home to Kingswood on 29 Month1 2019. RN E admitted Mr C to Kingswood, but there is no evidence that admission nursing assessments such as falls risk, or pain or skin assessments were completed, or that Mr C's weight and baseline observations were recorded. There is also no discussion of care and safety needs. As noted above, in response to the provisional opinion, Kingswood provided a handwritten note outlining the admission process, but RN E stated that this was not in her handwriting.

205. RN Ferreira said that the usual practice for residents living with a diagnosis of dementia mate wareware and transitioning to a new environment would be to commence a behaviour monitoring plan, supported by a specific nursing plan to outline individualised care and safety needs. These plans were not developed.

206. There was also no communication with the EPOA, Mr B, to inform him of Mr C's arrival at Kingswood or to involve Mr C's whānau in the admission process. RN Ferreira advised that it would be considered accepted practice to do so. Kingswood pointed to Mr B being advised of the transfer five days prior to admission, and the nursing note on the day of admission that the family had been informed, but both these were by the first care home staff and prior to his admission.

207. In my view, it was Ms D's responsibility to ensure that these processes took place as part of coordinating safe admissions. While Ms D was on leave for most of Mr C's admission to Kingswood, it does appear that Ms D was working for at least the first 72 hours of his admission, being 29 to 31 Month1 2019.

208. In response to the provisional opinion, Ms D advised that she was on leave from 17 Month1 to 8 Month2 2019, while Kingswood told HDC that she was on leave from 18 Month1 to 12 Month2 2019.

209. In addition to contradicting each other, these dates contradict the dates previously provided to HDC, and I note the following:

- Kingswood provided a copy of a typed short-term care plan that appears to be dated and countersigned on 29 Month1 2019 by Ms D.

- The communication diary had a sticker indicating that Mr G was on call instead of Ms D from 1 Month2 2019, along with instructions on other staff to contact for relevant issues.
- There is a communication diary entry written by Mr G on 3 Month2 2019, which indicates that Ms D gave directions to withhold another resident's breakfast and lunch PRN medications and for 'NO ONE to tell family. [Ms D] will do this', although the same sticker about on-call arrangement appears on this date.
- According to the statement of senior caregiver/clinical assistant Ms K, Ms D's start date of leave was 3 Month2 2019.

210. I therefore consider it more likely than not that Ms D's leave commenced on or after 1 Month2 2019, and she was present at work during the first 72 hours of Mr C's admission.

211. I note that RN E was qualified in New Zealand, and this was her first position post qualification. I consider that Ms D should have provided greater oversight of her, such as checking that the admission documentation was completed adequately and the nursing records maintained. Ms D should also have taken steps to ensure that Mr B had the opportunity to be involved in the admission process. In my view, Ms D should have arranged for RN L to attend Kingswood on a regular basis to provide clinical support to RN E, rather than expecting a junior registered nurse to recognise when she needed support and seek it out.

212. There was also a delay in Mr C being seen by the GP until 6 Month2 2019, approximately nine days after his admission to Kingswood. This was outside ARRC contractual requirements, and the internal policies indicate that this was the admitting nurse's responsibility. However, RN Ferreira noted that given that Mr C was known to staff (having transferred from another Kingswood facility), it is unclear why this process was not facilitated by Ms D (or RN L) prior to his transfer to the new care home, in line with their responsibilities to lead and direct safe resident admissions.

213. I agree that it was within the scope of Ms D's responsibilities to ensure that this occurred.

214. Kingswood told HDC that Mr C was seen by his GP the day before his transfer, arranged by RN L, and his admission weight and observations were 'carried over' from the first care home. However, as noted earlier, no documentation of this review has been received, nor are there any recordings of observations or weight in the Kingswood notes at any point during his entire admission. There seems to have been some involvement of another GP in charting Mr C's medications on 30 Month1, but there is no evidence of a review until 6 Month2 2019.

Complaints management

215. Ms D was responsible for ensuring that the complaints procedure was adhered to at all times, that all complaints were dealt with in writing, and for ensuring a positive outcome. Once Mr C's family raised concerns with Kingswood about the care provided to Mr C, there does not appear to have been any clear process followed to address these concerns.

216. Mr B said that he was contacted by a nurse on 8 Month2 2019, and then he contacted Ms D about his concerns. It is unclear who contacted Mr B on this date and there is no documentation of either of these calls. The next contact appears to have been on 13 Month2 2019, when Mr B contacted Kingswood to discuss his concerns and stated that he wanted Ms D to accept responsibility for the registered nurse's actions and make sure that this would not happen again, which reportedly she did.

217. There was no further contact until Mrs A telephoned Ms D on or around 24 Month2 2019, and it appears that there was a breakdown in their relationship during this call. Senior caregiver Mr G appears to have taken over as the intermediary between Mr C's family and Kingswood. Mr G contacted Mr B on 25 Month2 and met with him the following day, to return Mr C's belongings and discuss events.

218. An apology was sent by Ms D on 29 Month2 2019, but this did not provide any details of how Mr C's illness had progressed, or any outcome of a review or findings of the 'full investigation' stated to have been carried out. Following this, there appears to be no further documented action taken or communication provided to Mr C's family in response to the complaint, including provision of an investigation and review as requested, or confirmation of how Mr C's illness had progressed.

219. RN Ferreira noted that the Kingswood policies indicate that the manager is responsible for the complaints process, and that while Kingswood submitted event information that includes a complaint response, it is unclear whether Mr C's whānau were invited to meet with the provider in line with the organisation's policy and accepted practice standards. She advised that there appear to be opportunities for improvement with complaint management processes and documentation standards to reflect family/whānau involvement in meaningful, consumer-focused service delivery, and to ensure that services meet the appropriate standard.

220. In my view, Kingswood's management of the complaint made by Mr C's family and the information provided to them was inadequate. Most of the contact that occurred was prompted by Mr C's family making contact first. There is no evidence that Kingswood completed a review to answer Mr C's family's queries about their father's care, or provided details of its investigation, other than a written apology. There is no evidence of Kingswood having advised them of their right to complain to HDC. In my opinion, the communication that occurred in relation to Mr C's family's concerns did not instill confidence that appropriate changes had been made or that learning had been taken from this incident. As Ms D was responsible for the complaints process, I consider that these deficiencies in process are attributable to her.

221. I note also that it appears that no full investigation was undertaken despite Kingswood's submissions that this was done. RN I stated that Ms D requested that she investigate the incident, but there was no separate investigation findings report, nor any evidence that any investigation findings were provided to any of the parties involved. Incident reports by individual staff members that were provided were created many months after the events.

222. RN Ferreira noted that it is unclear from the provider's response why there were issues in applying the organisational processes to practice during the timeframe in question. She noted that the provider response (to HDC) has discussed factors that may have contributed to Mr C's decline, but the provider has not provided evidence of a corrective action plan in response to learning from this complaint. She noted that there is evidence that organisational policies have been reviewed and updated to reflect provider responsibilities to contact families and access on-call support, but opportunities remain for the care-home team to review policies and processes regarding resident admissions and related responsibilities for nursing assessment and care planning, teamwork, open communication, and informed consent.

223. RN Ferreira identified areas regarding staff training, leadership, complaint management, communication, and documentation standards that were a moderate to significant departure from accepted standards.

224. I accept this advice. In my view, it does not appear that Kingswood investigated the care provided to Mr C appropriately and took learning from this, other than identifying deficiencies in RN E's care. This meant that wider learning by the care team did not occur. In my opinion, Ms D was responsible for ensuring that these processes occurred.

Conclusion

225. Overall, I consider that by failing to coordinate the safe admission of Mr C, Ms D failed to provide services to Mr C with reasonable care and skill and breached Right 4(1) of the Code.

226. I also consider that Kingswood's response to Mr C's family's complaint was inadequate, and as Ms D was responsible for the management of the complaints procedure, I find that Ms D also breached Right 10 of the Code.

Opinion: RN E — breach

227. RN E was involved in Mr C's care from his admission to Kingswood on 29 Month1 2019 until his transfer to the public hospital on 6 Month2 2019.

228. RN Ferreira advised that rest-home and dementia-level care settings require the involvement of a registered nurse to assess, plan, and lead the residents' care. The care team's role is to deliver care in partnership with the registered nurse, resident, and family/whānau, and to document their actions and report their findings or concerns to the registered nurse or clinical lead. Registered nurses are required to review communication records and carer notes to identify changes, perform relevant nursing assessments to inform their clinical decision-making, and seek further health professional involvement as required. In my view, RN E failed to provide adequate care to Mr C as follows.

Mr C's admission

229. RN E, as a member of the admitting team, had several responsibilities in the admission of Mr C.

230. RN E recorded in the progress notes on 29 Month1 2019: 'Admitted [Mr C], transferred from [the first care home], walking with frame, confused, and settled after he was given tea. Admission cares done.' RN E's entry does not introduce Mr C as a new resident or discuss his care and safety needs, which RN Ferreira advised would be considered an accepted part of the admission nursing process. RN E accepted this but stated that it does not mean that it did not happen, just that it was not recorded.

231. There is also no record that RN E conducted admission nursing assessments such as falls risk, pain assessment, or skin assessment, or that Mr C's weight and baseline observations were recorded. While an incomplete 'behaviour chart' was provided by Kingswood,[21] it appears that RN E did not commence a behaviour monitoring plan, supported by a specific nursing plan to outline Mr C's care and safety needs. As noted by RN Ferreira, there is no evidence that RN E reviewed any nursing or medical transfer information, although RN E stated that it is her standard practice to review this information.

232. RN E also did not contact Mr C's EPOA, Mr B, or other family/whānau to inform them of Mr C's arrival at Kingswood and involve them in the admission process. RN Ferreira advised that to do so would be accepted practice. RN E stated that this was the admitting team's responsibility and noted that RN L had documented informing the family. However, this was prior to his transfer, and I agree with RN Ferreira and consider that the lack of contact inhibited the whānau's ability to support Mr C while he adapted to the new environment. RN E stated that she was not given any information about contacting families when she started working at Kingswood, but I note that communication with health consumers and supporting whānau/family participation are part of the competencies for registered nurses.[22] While it may not have been her sole responsibility, in my view she could have facilitated this as the admitting nurse.

233. RN E was responsible for informing the medical practice and pharmacy and completing relevant enrolment forms on the day of admission. RN E said that she had arranged Mr C's enrolment within a day or two of his admission. It appears that the GP clinic enrolment documentation was completed only on 6 Month2 2019, although it does appear that Mr C's new GP was involved in charting his medication on 30 Month1 2019, the day after his admission, which RN E suggests indicates that the GP was informed and had accepted him as a new patient.

234. While there is some evidence that the medical practice was informed of Mr C's admission (as evidenced by the GP charting his medication the day after his admission), in terms of enrolment, there is email evidence that RN E advised the GP of Mr C's admission only on 5 Month2 2019, and she sent through enrolment forms once prompted by the GP clinic on 6

[21] See paragraph 33.
[22] Competencies for Registered Nurses, Nursing Council of New Zealand.

Month2 2019. It seems unlikely that this correspondence would occur had she already sent enrolment forms earlier in his admission. Therefore, there does appear to have been a delay in enrolment.

235. I also note that a GP review was not carried out within two days of admission, and Mr C was first seen by the GP on 6 Month2 2019, outside the ARRC contractual requirements. Kingswood's policy was also that each resident should have a health and personal assessment completed on or within 72 hours of admission. There is no evidence that this occurred.

236. RN E noted Kingswood's statement that it had arranged a GP review the day prior to Mr C's transfer, to assist her in the admission process, but it had not provided evidence of this. RN E noted that it is possible that this did occur, and this would have informed her decision-making and would explain why Mr C was not seen by the GP within two days of admission whilst at Kingswood.

237. I have carefully considered this issue. If a GP review had occurred the day prior to transfer, not arranging a GP review within two days of admission (for admission processes) would be reasonable. While there is no evidence of this review, given the issues with Kingswood's information provision to HDC, I cannot discount the possibility that this did occur and merely has not been provided to HDC. I am therefore unable to make a finding in relation to RN E's role in whether there was a delay in arranging a GP review.

238. RN E noted also that a behaviour chart was provided belatedly, and Kingswood referred to other documentation such as falls risk assessment and weight/baseline observations, but it has not provided copies of this. She submitted that this does not mean that the documentation does not exist, but rather that it has not been provided (by Kingswood).

239. As above, in the circumstances I cannot discount the possibility that this documentation was completed and merely has not been provided. I do not consider that I can make a definitive finding that RN E did not complete these assessments. I therefore cannot make a clear assessment of the adequacy of RN E's admission process.

240. However, I note with criticism the lack of contact with Mr C's family and the delay in enrolment with the GP, and trust that RN E has reflected on these issues.

Deterioration

241. As part of the care team and the only registered nurse on site at Kingswood at the time of events, RN E was responsible for leading the delivery of care to Mr C and recognising (and escalating) any deterioration.

242. RN Ferreira advised that registered nurses are required to review communication records and carer notes to identify changes, perform relevant nursing assessments to inform their clinical decision-making, and seek further health professional involvement as indicated.

243. While at times there were inconsistencies in what was recorded in the communication diary compared to the progress notes in the care provided to Mr C, and some concerns identified by caregivers that were not documented at all or not escalated clearly and reported to the registered nurse (which I have addressed separately), I note the following entries that were documented and therefore would have been available to RN E:

a) The progress notes on 2 Month2 2019 report that Mr C had reduced oral intake and a sleepy presentation, and on 3 Month2 2019 that he had a swollen right foot and was asleep by 7.30pm, and the communication diary note states: '[T]o see RN regarding mucus in right eye. Also check him sleeping a lot and uncomfortable.' RN E told HDC that she does not recall seeing that diary note. She said that her practice was to review the communication diary every morning and, if the note had been written during the weekend, she would have seen it in the following week when she came into work. There is no evidence that RN E took action in response to these communication prompts.

b) The progress notes on 4 Month2 2019 at 10pm state that Mr C was restless, had refused dinner, and was in bed at 5pm. There was also a communication diary entry asking RN E to check Mr C's swollen right foot. There is no record that RN E assessed Mr C at this time.

c) The progress notes on 5 Month2 2019 at 3.35pm report that Mr C was in bed all day having vomited, and that he had taken only fluids during the shift. There is again no record of RN E's assessment of Mr C at this time.

244. RN Ferreira advised that in relation to the 2 and 3 Month2 entries, there is no evidence of any nursing actions in response to communication prompts when receiving handover, in line with shift guidance. In relation to the 5 Month2 entry, RN Ferreira advised that there is no evidence of any assessment by a registered nurse at that time, and accepted practice would have been to record Mr C's vital signs, compare the data to his baseline admission recordings, assess pain and hydration status, oral intake, and elimination patterns, and escalate concerns to the GP for further guidance. RN Ferreira also noted that there were no further entries in the progress notes nor evidence of any completed monitoring forms to inform additional comment. RN E said that she did review Mr C on this date, although she was not informed that Mr C had vomited and had not eaten anything and had had only fluids the previous day. I am unable to determine whether the healthcare assistant told RN E that Mr C had vomited, but I would expect a standard review of a resident would include queries of this nature.

245. As outlined earlier, while RN E has submitted that she contacted the GP clinic and interacted with the GP about her concerns on 5 Month2, there is no evidence of this. The only evidence available are two emails[23] to the GP clinic by RN E, and neither of these indicated any concerns about Mr C's condition or any urgency.

[23] On 5 and 6 Month2 2019, respectively.

246. RN E told HDC that on 6 Month2 2019, Mr C looked weaker and frailer. She recalled that the healthcare assistant said that she had tried to feed him, but he was not eating. He was sweating, so they decided to put him in a singlet with a blanket covering him. RN E cannot recall what time she was advised by the healthcare assistant that Mr C had deteriorated. RN E said that, to the best of her recollection, she took Mr C's observations, and Mr C was coughing, had a dry mouth, and was sweaty. She said that she took his temperature, and he did not have a fever. There is no nursing entry for that day. RN E said: 'I do not recall whether I documented those observations, but I may not have had time to record them.'

247. RN Ferreira advised that there is no evidence of nursing assessment or rationale to support decision-making recorded in Mr C's clinical file on this date. I agree. It is not possible to determine the extent to which RN E assessed Mr C given the lack of clinical records. I note that there is also no evidence that she contacted RN L when Mr C's condition deteriorated or requested support. RN E said that she was told not to call RN L regarding clinical concerns, and rather she would call the GP, district nurses, or palliative care nurses. However, there is also no evidence of her having contacted any of these parties for support on this date .

248. The GP saw Mr C for the first time on 6 Month2 2019, for what appears to have been a planned GP review. RN E said that she called the GP for review but there appears to be no evidence of this, and this is inconsistent with her previous statements about the GP attending for a booked review. By that time, Mr C was acutely unwell with a suspected lower respiratory tract infection, and he required urgent transfer to hospital for further care. The GP's notes refer to Mr C's rapid deterioration with signs of fever, shortness of breath, confusion, bilateral crepitations with a productive cough, and an oxygen saturation of 75%. RN Ferreira advised that it is concerning that RN E's nursing notes contain no record of Mr C having these symptoms. I agree.

249. In my view, from the evidence available, it appears that RN E failed to recognise how unwell Mr C was. As a result, appropriate actions and assessments did not occur.

250. RN E submitted that insufficient weight has been given to the failure of the care staff to record their observations and escalate their concerns, including that there was not an entry in the communication diary on 5 Month2 2019. I have addressed these matters separately but note that irrespective of this, and as stated earlier, registered nurses are required to review care notes to identify changes and perform relevant nursing assessments to inform clinical decision-making. In my view, there were sufficient concerns documented to prompt nursing assessments, and RN E should have recorded her own observations and findings.

251. RN E also submitted that the failure to document clinical notes has been conflated with failure to have adequately identified and attended to Mr C's deterioration on 6 Month2 2019. She stated that on 6 Month2 2019 she fully appreciated that Mr C had deteriorated markedly from 5 Month2 2019, and she referred to the GP's record and the ambulance notes about symptoms increasing from the previous night.

252. In my view, if RN E had recognised Mr C's deterioration, she should have recorded her assessments to support her decision-making, and it is unclear why she did not request a more urgent GP review or consider alternative escalation, and instead she waited for the planned GP review. I do not consider her busyness to absolve her responsibilities in the care of an unwell patient.

Contact with family and transfer to public hospital

253. RN E did not contact Mr B or other family/whānau to inform them that Mr C was unwell and about to be seen by a GP, nor did she contact them about his transfer to the public hospital. RN E stated that it was a very busy shift and, after the ambulance left, she was preoccupied with other staff and 'totally forgot' to call Mr C's family. RN Ferreira advised that the lack of contact would be considered below accepted clinical practice standards and service provider responsibilities.

254. RN Ferreira advised that care decisions are made in partnership with the EPOA, and registered nurses are required to show these interactions in the resident's family/whānau contact record, care plan, progress notes, and any relevant meeting minutes.

255. RN Ferreira said that evidence of communication with a resident's nominated representative is a fundamental element in the nursing process. She advised that the apparent lack of communication between the care-home team and Mr C's EPOA, and the lack of related documentation, would be considered a serious departure from the accepted standard of practice. In my view, it was RN E's responsibility to ensure that the family were contacted. I do not consider that her workload absolved her of this responsibility, and at the very least she could have delegated this to another staff member. RN E also noted the practice at Kingswood where Ms D would direct her or a caregiver to contact family members as needed, but I do not consider this relevant, as Ms D was not working on this date, nor is this something RN E needed instruction on.

256. RN Ferreira also advised that the lack of communication appears to have affected Mr C's right to have a support person present at the care home and hospital, which is very important when caring for an unwell resident with a diagnosis of dementia mate wareware, particularly in an unfamiliar environment.

257. I agree. I note Mr B's comments that they had no opportunity to visit Mr C or speak with the doctor, and it is concerning that Mr C's EPOA and Mr C's family were deprived of this opportunity, particularly for a vulnerable person such as Mr C. I am also very critical that Mr C's EPOA and Mr C's family found out only from the public hospital that Mr C had been unwell and had been taken to hospital.

258. RN Ferreira noted that Kingswood's Clinical Service Manual states that nursing documentation should reflect the time and how a resident leaves Kingswood, and that the resident's family should be notified before and after the transfer. RN Ferreira advised that there is no evidence in Mr C's clinical file that organisational steps were applied, which would be considered a serious departure from accepted practice. I accept this advice.

Record-keeping

259. The Nursing Council of New Zealand Code of Conduct for Nurses (2012) states that nurses should keep clear and accurate records of discussions and assessments made. In addition, nurses should ensure that entries in a patient's clinical records are clearly and legibly signed, dated, and timed. The registered nurse position description required RN E to document all appropriate records.

260. The only nursing entry in Mr C's clinical file during his time at Kingswood is the admission entry on 29 Month1 2019. RN E said that she reviewed Mr C on 5 and 6 Month2 2019, but there is no documented evidence of this, which she could not now explain but suggested may have been due to time limitations and workload. RN E said that she took Mr C's observations, and her normal practice was to record observations in a progress note as residents' standard monthly observations were recorded on a separate sheet.

261. There is no evidence of RN E's involvement in Mr C's care after 29 Month1 2019, which RN Ferreira advised would be considered a serious departure from accepted practice standards and professional responsibilities. I agree.

262. As outlined earlier, there is also no documentation of contact with the GP at the times RN E submitted, or information about Mr C's transfer to the public hospital.

Conclusion

263. RN E had only recently completed the Competency Assessment Programme with the New Zealand Nursing Council and obtained an annual practising certificate. RN E told HDC that at the time of events, this was her first job after graduating from the Competency Assessment Programme. RN E worked from 8am to 4pm and was also required to be on call after hours. I acknowledge that RN E had a heavy workload and a lack of in-person clinical support.

264. Nevertheless, in her care of Mr C, RN E did not communicate with his EPOA and whānau/family on admission and when he became unwell. In addition, she did not inform his family when he was seen by the GP and when he was transferred to hospital. Although Mr C was seriously ill at the time of his transfer to hospital, RN E failed to recognise the extent of his deterioration and take urgent steps, and she did not complete the required documentation. I do not think her busyness and lack of support excuses these failings. Accordingly, I find that RN E failed to provide services to Mr C with reasonable care and skill and breached Right 4(1) of the Code.

265. I also consider that RN E's documentation in her care of Mr C was inadequate and did not meet accepted standards. Accordingly, I find that RN E breached Right 4(2) of the Code.

Opinion: First care home — adverse comment

266. Mr C transferred from the first care home to Kingswood on 29 Month1 2019.

267. The nursing progress notes from the first care home reflect that prior to Mr C's transfer, a nursing handover was provided to the nurse at Kingswood, and that Mr C's family had been informed. RN Ferreira noted that there is no documentation of relevant nursing information, such as a transfer/discharge form, Mr C's health status, medication management, time of transfer, or transport processes, which would be accepted practice in the circumstances.

268. In addition, Mr C's last interRAI assessment had been completed a few months prior to the transfer, and a continuing care plan was in place. RN Ferreira said that both documents discuss Mr C's care requirements and agreed support at the time of assessment, but there was no care evaluation prior to his transfer on 29 Month1 2019, and no reason recorded for the transfer.

269. RN Ferreira said:

> 'It is unclear why InterRAI assessment information was not updated in line with ARRC contractual responsibilities if [Mr C] required a change in care level or whether NASC services were involved in [Mr C's] review and transfer of care process, as outlined in the ARRC agreement.'

270. In response to the provisional opinion, Kingswood advised that there had not been a change in care level, as Mr C had been receiving dementia-level care at the first care home and would be receiving the same at Kingswood.

271. I remain concerned that it does not appear that Mr C was assessed adequately prior to his transfer. I consider that the first care home did not hand over Mr C's care to Kingswood adequately to ensure continuity of care and that his needs would be met. I have made a relevant recommendation below.

Changes made

272. Kingswood told HDC that since this incident it has undertaken the following:

- Incorporated a new robust registered nurse orientation form into the registered nurse orientation.
- Added the requirement to communicate with whānau/family into the registered nurse checklist.
- Held a staff meeting to discuss empowering caregivers to question and ask whether things have been done when they are concerned.

- Changed the way training/orientation is provided to caregivers, registered nurses, and any other staff members, and now has an extensive range of external educators, including nurse practitioners and clinical nurse specialists from Health New Zealand's Mental Health Service for Older People.
- Arranged for HDC advocates to provide education for staff and used HDC's DVD for training staff.
- In 2022 it added HDC's online education for all staff to complete as part of their orientation package.

273. In response to the provisional opinion, Kingswood said that Ms D has attended training in complaint management with the Aged Care Association, as well as attending a leadership development programme, which included training in behavioural styles, communication, and conflict management. It said that Ms D also completes HDC's online training yearly.

274. Kingswood also advised that it has since made changes to its company structure, including a senior staff member stepping in for Ms D when she is not on site, and it has added a layer of middle managers.

Recommendations

275. I recommend that within three weeks of the date of this opinion, Kingswood Healthcare Morrinsville Limited, Ms D, and RN E each separately provide a formal written apology to Mr C's family for the failings identified in this opinion. The apologies are to be sent to HDC for forwarding.

276. I recommend that within three months of the date of this opinion, Kingswood Healthcare Morrinsville Limited:

a) Provide HDC with a corrective action plan in response to learnings from this complaint and review its policies and processes regarding resident admissions and responsibilities related to nursing assessment and care planning, teamwork, open communication, and informed consent. Evidence of the corrective action plan, and the outcome of its review of policies and processes (including any updated policies and processes) are to be provided to HDC.

b) Arrange for the Kingswood care-home team to complete additional education on person-centred care and effective communication with and about older people and their family/whānau, including strategies for ensuring that changes in resident needs are documented adequately and communicated appropriately. As part of this, Kingswood should consider implementing the ISBAR communication tool to better inform clinical assessments, actions, and safe, evidence-based decision-making. The content of the training and proof of staff attendance, and the outcome of its

consideration of implementing the ISBAR communication tool and any related actions, are to be provided to HDC.

c) Arrange for the Kingswood care-home team to undertake relevant clinical education about the assessment and care of older people, including documentation and reporting responsibilities. As part of this, alongside its clinical policies and procedures, Kingswood is to consider implementing the Health Quality and Safety Commission Frailty Care Guides (guidance about signs of acute deterioration and related actions), the STOP and WATCH tool, and upcoming guidance on the Deterioration Early Warning System (DEWS). The content of the training and proof of staff attendance, and the outcome of its consideration of implementing these tools and any related actions, are to be provided to HDC.

d) Arrange for the nursing staff at Kingswood to undertake further education regarding effective direction, delegation, supervision of the care team, and reflective practice. The content of the training and proof of staff attendance are to be provided to HDC.

e) Provide HDC with evidence of the updated qualified nurse induction and orientation, clinical education, skill development, and competency processes, including peer support and mentoring for junior or new-to-practice registered nurses. As part of this, Kingswood is to consider whether any further updates are required, and consider RN Ferreira's advice that the Clinical Manual, registered nurse job description, and registered nurse orientation checklist do not appear to refer to the Nursing Council of New Zealand competency framework, guidelines, and relevant standards aligned to the Code of Conduct.

f) Arrange for the care-home team to complete the HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/ — and provide evidence of each staff member having done so.

277. I recommend that within three months of the date of this opinion, RN E undertake additional education on person-centred care and effective communication with health consumers and complete the HDC online modules for further learning: https://www.hdc.org.nz/education/online-learning/. Evidence of attendance at related training and completion of the online modules is to be provided to HDC.

278. I recommend that within three months of the date of this opinion, the first care home review its transfer procedures, and, as part of this, consider developing specific guidance for transfer between two facilities, noting RN Ferreira's advice that there is limited discussion in policy information regarding the organisation's process for in-house transfers between the provider's care homes, which may be an opportunity for improvement. Evidence of this review of procedures and details of any changes made are to be provided to HDC.

Follow-up actions

279. Kingswood Healthcare Morrinsville Limited 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.

280. A copy of this report with details identifying the parties removed, except the advisor on this case, Kingswood Healthcare Morrinsville Limited, and Kingswood Rest Home will be sent to the Nursing Council, and it will be informed of RN E's name.

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

Appendix A: In-house advice to Commissioner

'**CLINICAL ADVICE — AGED CARE**

CONSUMER : [Mr C]

PROVIDER : Kingswood Healthcare

FILE NUMBER : C20HDC00526

DATE : 20 July 2023

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Kingswood Healthcare. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **Documents reviewed.**
   Letter of complaint dated 11 March 2020

   Provider responses dated 15 July 2020, 24 May 2022

   Clinical records including nursing assessment, care plan, progress notes, medical notes, and communication records.

   Additional information received 27 May 2022 including job descriptions, role task lists, clinical services manual, employment information, email correspondence.

   Additional information received 21 June 2023 including provider response, outline of organisational structure, resident pre-entry policy and procedure, open disclosure policy, complaint management policy, staff development policy, orientation and training records, and registered nurse role information.

3. **Complaint**
   [Mr C's] family have expressed concern regarding a lack of care, poor communication, and delayed treatment while [Mr C] was a resident at the care home in Month2 2019.

4. **Review of clinical records**
   For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

- The care home admission process, clinical leadership and oversight of resident care, communication, and documentation standards.
- Organisational processes, complaint management and areas for improvement.

Background

[Mr C] transferred from the first care home to their Morrinsville care home on 29 Month1 2019. His medical history included atrial fibrillation, hyperlipidaemia, hypertension, osteoporosis, polymyalgia, and dementia mate wareware. Clinical information indicates [Mr C] was independently mobile with a walking frame and required moderate supervision with activities of daily living. [Mr C] became unwell, requiring transfer to hospital on 6 Month2 2019 and [subsequently,] passed away … related to his medical presentation. I extend my condolences to [Mr C's] family at this time.

a) Was the care provided to [Mr C] appropriate in the circumstances.

[Mr C's] family have expressed concern regarding the care provided to him between 29 Month1 2019 and his transfer to hospital on 6 Month2 2019.

Admission process

The organisation's clinical services manual (July 2019) and supporting policies provide clear guidance regarding admission expectations and service provider responsibilities, in line with the Age-Related Residential Care (ARRC) service agreement. The senior staff member's job description discusses responsibilities for the coordination of safe resident admissions, in partnership with the other senior staff members. The … role … is supported by registered nurses (RN), enrolled nurses (EN), and carers.

The clinical services manual outlines admission day responsibilities and refers to the use of an admission checklist for the admitting team to follow. There is evidence of an RN task list to assist the admission process which provides instructions regarding completion of admission documents, setting up of clinical files, care home lists, nursing assessments and care plans. These steps are also reflected in the RN orientation book. The document states that enrolment forms for the medical practice and pharmacy will be completed on the day of admission and that a GP visit will be scheduled within two working days to medically admit the new resident, which is in line with accepted practice.

[Mr C] transferred from [the first care home] to Kingswood Morrinsville Care Home on Tuesday, 29 Month1 2019. RN progress notes from the [first] care home reflect that a nursing handover had been provided to the nurse at the new care home, and that [Mr C's] family had been informed. There is no discussion of relevant nursing information, such as a transfer/discharge form, [Mr C's] health status, medication management, time of transfer or transport processes which would be accepted practice in the circumstances.

RN progress notes recorded at 1500hrs on 29 Month1 2019 state "*Admitted [Mr C], transferred from [the first care home], walking with frame, confused, and settled after he was given tea. Admission cares done".* The RN entry does not introduce [Mr C] as a new resident or discuss his care and safety needs which would be considered an accepted part of the admission nursing process. There is no evidence that admission nursing assessments such as falls risk, pain or skin assessments were completed or that [Mr C's] weight and baseline observations were recorded. There is no evidence that a short-term care plan was commenced to support [Mr C] during his settling-in phase to the care home. Usual practice for residents living with a diagnosis of dementia mate wareware and transitioning to a new environment would be to commence a behaviour monitoring plan, supported by a specific nursing plan to outline individualised care and safety needs.

It is unclear if any nursing and medical transfer information was reviewed by the admitting team at this time, particularly when he was last seen by a GP prior to his transfer to Kingswood Morrinsville. There is no evidence of communication with [Mr C's] nominated representative, family/whānau to inform them of his arrival at the care home or acknowledge their involvement in the admission process which is considered accepted practice. Given [Mr C] was known to the organisation and transferring [from another care home] it would be accepted practice for a coordinated plan to be in place, facilitated by [a clinical lead], to ensure the receiving care team were aware of [Mr C's] care and safety needs while settling into his new home.

Policy information states that each resident will have a health and personal assessment completed on or within 72 hours of admission, and a lifestyle care plan completed within 3 weeks of admission, which aligns to service provider responsibilities. Reviewed clinical information indicates that [Mr C's] last InterRAI assessment was completed on …, with a continuing care plan in place dated … Both documents provide discussion of his care requirements and agreed support at the time of assessment, but there is no evidence of care evaluation prior to transferring on 29 [Month1], nor rationale provided for his change in care circumstances. It is unclear why InterRAI assessment information was not updated in line with contractual responsibilities if [Mr C] required a change in care level or whether NASC services were involved in [Mr C's] review and transfer of care process, as outlined in the ARRC agreement.

Organisational information discusses the care home's medical admission process and the clinical task list shows that the admitting nurse is responsible for informing the medical practice and pharmacy and completing relevant enrolment forms on the day of admission. [Mr C] arrived at the care home on … 29 [Month1], however it appears that enrolment documentation was only completed on … 6 [Month2] 2019. It is unclear why this process was delayed, and why [Mr C] was only first seen by a GP on 6 [Month2] 2019, which is outside of contractual requirements. Given [Mr C] was known to [RN L] and RN team it is unclear why this process was not facilitated by [RN L] or

[Ms D] prior to his transfer to the new care home, in line with their role responsibilities to lead and direct safe resident admissions.

Shift handover

The RN orientation book provides an outline of shift handover processes which includes reviewing the communication book, visits to all communities to receive a verbal update from duty teams, visual checks of all residents, and essential document review. The RN task list refers to receiving handover from the previous shift and outlines shift responsibilities. Information states that "*if residents are sick, look for infections and pain, contact GP if needed"*. There is no reference to types of assessments, decision-making tools, or use of on-call senior nurse support which would be valuable resources for a junior RN. The document refers to the use of a care home diary, communication book and handover sheets, outlining carer responsibilities but there is limited information about teamwork, leadership responsibilities and direction and delegation of resident care.

It is unclear what process was followed for introducing new residents to the care team in verbal and written form across different shifts, to discuss care and safety requirements. As [Mr C] was known to the organisation and transferred [to another care home] with an established nursing care plan, it would be recommended practice that the [previous care home] provide orientation, care oversight and guidance to the junior RN and care team during [Mr C's] settling-in phase. There is no evidence of care leadership by the [first care home] or related organisational oversight of the … process within the submitted documentation, or wider discussion to suggest these responsibilities occurred.

Documentation

Submitted organisational information provides discussion of care home documentation requirements, and states that resident progress notes will be written every 24 hours. Rest home and dementia level care settings require RN involvement to assess, plan, and lead resident care. The care team's role is to deliver care in partnership with the RN, resident and family/whānau, document actions and report their findings or concerns to the RN or clinical lead. RNs are required to review communication records and carer notes to identify changes, perform relevant nursing assessments to inform their clinical decision-making and seek further health professional involvement as indicated. It is usual practice for care home teams to ensure newly admitted residents are closely monitored and supported during the settling-in phase, with clinical file information regularly reviewed and updated accordingly.

Progress notes on 2 [Month2] 2019 report that [Mr C] had reduced oral intake and a sleepy presentation. On 3 [Month2] carers comment that [Mr C] had a swollen right foot and was asleep by 7.30pm. Progress notes do not discuss reports of pain or reduced mobility, signs of breathlessness or concerns about oral intake or elimination patterns observed by the care team. It is unclear if senior carers recorded [Mr C's]

vital signs at this time to inform an RN nursing assessment which would be considered appropriate in the circumstances.

The provider has submitted copies of diary entries which indicate that carers were concerned about [Mr C]. On 3 Month2 2019 a diary note states "*to see RN regarding mucus in right eye. Also check him sleeping a lot and uncomfortable"*.

There is no corresponding entry evidenced in progress notes that describe signs of eye redness or discharge, or that concerns were reported to the on-duty or on-call RN. The observed swelling in [Mr C's] right foot does not appear to be diarised for RN assessment. There is no evidence of any RN actions in response to communication prompts when receiving handover, in line with shift guidance.

Progress notes on 4 [Month2] 2019 report that [Mr C] was restless, had refused dinner and was in bed at 5pm. It is unclear if alternative dietary options were considered, or supportive interventions offered by the senior carers. There is no evidence that any preliminary assessment occurred at this time, or if concerns were handed over to the next shift. Progress notes on 5 [Month2] 2019 report that [Mr C] was in bed all day following a vomiting episode and had only taken fluids across the shift. There is no evidence available to indicate that carers escalated concerns to the on-duty or on-call RN for support, or that any RN assessment occurred at this time. Accepted practice would be to record [Mr C's] vital signs, compare data to his baseline admission recordings, assess pain and hydration status, oral intake, and elimination patterns, and escalate concerns to the GP for further guidance. There are no further entries recorded in progress notes by qualified or care staff at this time nor evidence of any completed monitoring forms to inform additional comment.

A diary entry by an RN on 6 [Month2] 2019 refers to collection of a urine specimen ahead of the planned GP round, however there is no evidence of RN nursing assessment or rationale to support decision-making recorded in [Mr C's] clinical file. There is no evidence of communication with [Mr C's] nominated representative or family/whānau to inform them that [Mr C] was unwell and due to be seen by a GP which would be considered accepted practice in the circumstances.

Clinical notes reflect that [Mr C] was seen by his GP for the first time on 6 [Month2] 2019. [Mr C] was assessed as acutely unwell with a suspected lower respiratory tract infection and required urgent transfer to hospital for further care. Medical notes discuss [Mr C's] presentation, commenting on rapid deterioration with signs of fever, shortness of breath, confusion, bilateral creps with a productive cough, noting oxygen saturation levels of 75%. Nursing notes provide no discussion of resident presentation in line with these findings which is concerning.

File evidence shows that daily entries in progress notes were completed by carers, however there is only one RN entry evidenced in [Mr C's] clinical file during his time at the care home, dated 29 [Month1] 2019. There is no evidence of further RN involvement in [Mr C's] care which would be considered a serious departure from

accepted practice standards and professional responsibilities and viewed similarly by my peers.

Resident transfers

The clinical services manual outlines nursing responsibilities for transferring residents to another health provider, stating that a transfer/discharge form will be completed, nominated representative informed, and transport arranged. For those transferring to hospital, the organisation states that the resident will be physically prepared, dressed appropriately, noting "*no personal items at all except what resident is wearing; teeth and glasses are to accompany the resident to hospital".*

The clinical services manual states that nursing documentation will reflect the time and how the resident left the care home, and that families will be notified before and after transfer. [Mr C's] family have expressed concern that they were not informed of his health status or subsequent transfer to hospital. There is no evidence in [Mr C's] clinical file that organisational steps were applied which would be considered a serious departure from accepted practice.

As a comment, there is limited discussion in policy information regarding the organisation's process for in-house transfers between the provider's care homes, which may be considered as an opportunity for improvement.

From the evidence reviewed to respond to this question it appears there are identified areas of concern regarding clinical leadership and oversight of RN practice, completion of timely nursing assessments and care planning, recognition of resident decline, clinical decision-making, and care escalation. There are also identified departures in communication processes, teamwork and documentation standards which would be viewed similarly by my peers.

- Departure from accepted practice: Significant

b) Was communication with [Mr C's] family acceptable in the circumstances?

The Ngā Paerewa Health and Disability Service Standards (HDSS) and Age-Related Residential Care (ARRC) Services Agreement require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in the resident's health condition or of any adverse event. The organisation's Open Disclosure policy (Jan 2019) states that disclosures of harm will be made in a timely manner, ideally within 24 hours of the event occurring, or harm or error being recognised. The organisation's Complaint Policy and Procedures (May 2022) acknowledges service provider responsibilities regarding timely investigations, communication, and reporting processes.

[Mr C's] family/whānau have expressed concern regarding the lack of communication about their father's health status and transfer to hospital. As identified in question (a), there appear to be difficulties with documentation standards, with no record of

interaction between [Mr C's] EPOA and the new care home team in the family/whānau contact form. There is no record of communication regarding [Mr C's] admission, health concerns, GP assessment or transfer to hospital which would be considered below accepted clinical practice standards and service provider responsibilities. [Mr C's] son [Mr B], in his role as EPOA and as the consumer's decision-maker, had the right to be informed and to give informed consent to any proposed changes to care. Care decisions are made in partnership with the EPOA, and RNs are required to evidence these interactions in the resident's family/whānau contact record, care plan, progress notes and any relevant meeting minutes. Lack of communication also appeared to impact [Mr C's] right to have a support person present at the care home and hospital. Having a support person present is of significant importance when caring for an unwell resident living with a diagnosis of dementia mate wareware, particularly in an unfamiliar environment.

From the evidence reviewed to respond to this question it appears the communication between the care home and [Mr C's] whānau was below the accepted standard of practice in the circumstances. Evidence of communication with a resident's nominated representative is an essential part of service provider responsibilities and a fundamental element in the nursing process. The apparent lack of communication between the care home team and [Mr C's] EPOA, and lack of related documentation would be considered a serious departure from the accepted standard of practice and viewed similarly by my peers.

- Departure from accepted practice: Significant.

c) Please provide comment on organisational policies and supporting information, practice standards and complaint management processes.

From the information provided it appears that the policies and procedures in place at the time of [Mr C's] admission were adequate, as evidenced through the Manatū Hauora|Ministry of Health external health certification process, under the Health and Disability Services (Safety) Act 2001. However, it is unclear from the provider's response why there were issues in applying the organisational processes to practice during the timeframe in question. The provider response has discussed factors that may have contributed to [Mr C's] decline but not provided evidence of a corrective action plan in response to learnings from this complaint. There is evidence that organisational policies have been reviewed and updated to reflect provider responsibilities to contact families and access on-call support, however opportunities remain for the care home team to review policies and processes regarding resident admissions and related responsibilities to nursing assessment and care planning, teamwork, open communication, and informed consent.

There appears to be dissatisfaction raised regarding the care home's management of the complaint process. As outlined in organisational information, the manager is responsible for ensuring that the complaints procedure is adhered to at all times, and that all complaints are dealt with in writing to ensure a positive outcome. The provider

has submitted event information which includes a complaint response however it is unclear if [Mr C's] whānau were invited to meet with the provider in line with the organisation's policy and accepted practice standards. There appear to be opportunities for improvement with complaint management processes and documentation standards to reflect family/whānau involvement in meaningful, consumer-focussed care delivery, and to ensure that services meet the appropriate standard.

From the clinical information reviewed, it is unclear whether the care home team recognised signs of [Mr C's] health decline. The provider response does not discuss contributing factors to delays in recognising and acting on [Mr C's] observed health changes by the care home team at the time. The Health Quality and Safety Commission's Frailty Care Guides provide guidance about signs of acute deterioration and related actions (HQSC, 2019). These recommended resources can be used to inform clinical decision-making, partnered with the STOP AND WATCH tool and ISBAR communication tool. This presents an improvement opportunity for the provider to consider implementing alongside their clinical policies and procedures. To support this, I recommend the care home undertake relevant clinical education about the assessment and care of older people, including documentation and reporting responsibilities. Qualified nurses may also benefit from further learning regarding effective direction, delegation, and supervision of care teams, and reflective practice.

The provider has submitted a Staff Development policy (January 2023) which refers to responsibilities to carer training requirements. The document discusses the organisation's focus on competency-based orientation and refers to industry training requirements. The Clinical Manual, RN job description and RN orientation checklist discuss RN role tasks and responsibilities but do not appear to reference the Nursing Council of New Zealand competency framework, guidelines, and relevant standards, aligned to the Code of Conduct (NCNZ, 2012a; 2012b; 2022). This presents an improvement opportunity to review qualified nurse induction and orientation, clinical education, skill development and competency processes, including peer support and mentoring for junior or new-to-practice RNs.

From the evidence reviewed to respond to this question it appears that organisational policies and procedures were adequate and relevant at the time of [Mr C's] admission, however there are identified areas for improvement regarding staff training, leadership, complaint management, communication, and documentation standards, which would be viewed similarly by my peers.

- Departure from accepted standards: Moderate to significant.

5. **Clinical advice**

Based on this review I recommend the care home team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future.

I recommend the care home team complete additional education on person-centred care and effective communication with health consumers and consider implementing the ISBAR communication tool to better inform clinical assessments, actions, and safe, evidence-based decision-making. To support this approach, I recommend that the care home team complete the HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

References

Health and Disability Commissioner. (2022). Online Learning. https://www.hdc.org.nz/education/online-learning/

Health Quality and Safety Commission. (2019). Frailty Care Guides. http://www.hqsc.govt.nz/

Nursing Council of New Zealand. (2012a). Code of Conduct

Nursing Council of New Zealand. (2022). Competencies for registered nurses.

Nursing Council of New Zealand. (2012b). Guidelines: Professional Boundaries.'

The following further advice was provided by RN Ferreira:

'**Request for additional comment: 26 March 2024**

Thank you for the opportunity to review the provider's response and supporting information, including clinical records and statements from care home employees, and consider changes to my initial advice.

The provider has discussed their on-call process and team availability at the time of [Mr C's] admission, and I acknowledge their concerns regarding care escalation. The provider accepts that communication processes require improvement and has discussed orientation, education and training opportunities, provided in partnership with a range of specialised health professionals.

I have reviewed the submitted evidence, my initial advice and the additional information and in my opinion my advice remains relevant. [Mr C] was entitled to receive an appropriate standard of care and I consider the care provided to him was below the accepted standard in the circumstances.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner'

Appendix B: Kingswood policies and procedures

Kingswood Rest Home

Clinical services manual (July 2019)
The clinical services manual (the manual) includes:

'• Each resident has a health and personal assessment completed on or within 72 hours of admission.

- Initial assessments include personal data, pre-admission home/social situation, pre-admission activities of daily living, current medications, and any known allergies to medication.
- A planned ongoing programme of re-assessments ensures residents are re-assessed 3 monthly.
- Medical assessment is carried out within 2 days of admission, and thereafter at least three monthly, or more often should it be necessary, and the findings and any orders noted in the resident's clinical records maintained in the Home.
- Clinical records are available to carers at all times, whilst maintaining the records security
- Each resident has a written Lifestyle Care Plan including their activities of daily living based on the assessment findings, recorded in language easily understood by carers.
- Each 24-hour period progress notes on the resident are written.'

The manual states that all staff observations and assessments must be reported and written down 'by someone' and that reports are in some cases verbal, in other cases written. It states that it is Kingswood's policy that all shifts (am, pm, and night**)** complete progress notes at the end of each shift.

The manual states that a report will be written on the handover sheet at the completion of each shift and the carer caring for the resident on that day is responsible to ensure that this is written. The manual also states that a report on each resident is a requirement in each 24-hour period. A handover to oncoming staff must also be given by each carer before they go off duty.

The manual states that when a resident is transferring to [a public hospital], the resident must be prepared physically — dressed appropriately and their belongings packed. The manual also states that no personal items except what the resident is wearing, and their teeth and glasses (if required) are to accompany the resident to hospital. The (then) … Emergency Care Referral Form must be completed and this accompanies the resident. A copy of the resident's current Medication Chart and Doctor's chart also accompanies the resident. Documentation regarding the time and how the resident left the rest home is to be completed and family notified before and after the transfer.

The manual does not specifically refer to notifying whānau/family of a resident should they become unwell or require a GP assessment.

Clinical Manager job description
The Clinical Manager's job description states that … the Clinical Manager is to provide high-level clinical leadership and support to clinical and care staff.

[Ms D's] job description
Ms D's job description includes responsibility for the day-to-day smooth running of the home at every level and notes that the [person] must be qualified, competent, and experienced to run the care home and meet its stated purpose, aims and objectives. In addition it states:

> 'To be involved in producing and making available documentation setting out the aims, objectives, philosophy of care, services and facilities and terms and conditions of the home.
>
> …
>
> To ensure that all Residents be assessed prior to admission, evidencing that their needs can be met at the home and that emergency admissions be assessed as soon as possible by [a mental health service]. It is the responsibility of the General Manager together with the Registered Nurse, to ensure that this request is submitted on the next working day after admission.
>
> …
>
> To ensure that all Residents have a plan of care/support prepared by the Registered Nurse and that each individual and/or their representatives have been involved in drawing up their care plans.
>
> To ensure that the complaints procedure is adhered to at all times, and that all complaints are dealt with in writing and to ensure a positive outcome.
>
> …
>
> To ensure staffing levels and skill mix are consistent with Resident needs and the Home's occupancy, in line with company policy. To ensure that a minimum of 2–4 weeks' rosters are completed and made available.
>
> …
>
> Ensure that all information that is requested is completed accurately and within time guidelines set.
>
> …
>
> To ensure that care plans are "Person Centered" and compiled for each Resident, by the R.N. following full assessment.

To ensure that care plans are completed following full assessment of Resident's needs, by the RN within 72 hours of admission and invite participation from the Residents, their families/whānau.'

The registered nurse orientation book provides an outline of the shift handover processes, including reviewing the communication book, visiting all units to receive a verbal update from duty teams, visual checks of all residents, and review of essential documents.

Registered nurse task list (updated 19 [Month2] 2019)
Kingswood's registered nurse task list provides instructions regarding completion of admission documents, setting up of clinical files, care home lists, nursing assessments, and care plans. These steps are also reflected in the registered nurse orientation book. The enrolment forms for the medical practice and pharmacy are required to be completed on the day of admission by the registered nurse, and a GP visit scheduled within two working days to admit the new resident medically.

The registered nurse task list refers to receiving handover from the previous shift and outlines shift responsibilities. The information states that 'if residents are sick, look for infections and pain, contact GP if needed'. There is no reference to types of assessments, decision-making tools, or use of on-call senior nurse support.

The registered nurse position description includes:

'• To observe the condition of all residents and report any changes to the appropriate Manager promptly, as well as documenting in all appropriate records.
- To ensure each resident is treated with respect and dignity is maintained at all times.
- Include resident, where possible, in any discussion or decision making that affects their care or environment. If Resident is not capable, then include his or her EPoA where possible.'

There are two parts highlighted as having been added 'since the [Mr C] incident':

'• Contact families when and if needed, e.g GP visit, going to hospital, falls etc …
- Remember if you need help with anything reach out to the Clinical Manager, GM, EN and they will help, I am always only a phone call away, my phone is always with me.'

Appendix C: Excerpts from Kingswood's internal investigation letter

'Upon finishing the investigation, I found many faults with the handling of the late [Mr C's] care which I have listed below:

- [RN E] had been contacted several days before [Mr C] was sent to hospital, with concerns of his deteriorating health. No documentation from [RN E] regarding this.
- Progress notes completed by staff documented the deterioration of his health.
- Calls had been made to [RN E] over the weekend, as the on call medical support person in which she ignore[d] the call.
- The communication book had notes for [RN E] to come and sight [Mr C] … which did not happen.
- No nursing notes at all from the day he arrived in Morrinsville from [the previous care home], on 29 [Month1] 2019.
- Conversations had with staff regarding this situation, all stated [RN E] said she was busy with another resident, who was not even on site he had gone home for a visit, leaving at 09.30.
- Staff also stated that she got angry with them when they kept asking her to sight him, when she did sight him all she said was bedrest and push fluid and get a urine sample, which the staff [were] unable to collect, due to his dehydration. He was throwing up secretions and she did nothing to help that, the 2-care staff had to place him on his side to help relieve this. I have requested this to be put in accident/incident forms: please see attached. As noted in the discharge summary (see attached) [Mr C] had bi-lateral bronchopneumonia and [RN E] should have noted the secretions used her clinical judgement and realised that [Mr C] was acutely unwell and escalated her concerns.
- No family communication notes from [RN E] stating she had spoken to the family regarding his transfer to the hospital. Even though our policy and procedure state the RN, … , or anyone else advised too to contact family as soon as they get ill, see GP, or sent to hospital.

  …

  On the 24 June 2020 another complaint, this time from the Health and disability commission from [Mr C's] family. I began to investigate this again.

Apart from what I have stated above, more findings below:

- No notification to the GP about [Mr C] being unwell, only an email stating he was due for his 3 monthly GP visit on the 5 [Month2] and a confirmation email on the 6 [Month2] with times for this: see email attached, never once did she mention to the GP that [Mr C] was very unwell and needed GP input ASAP. As she was in communication with the GP I do not understand where the 'I was told not to

contact GP' came from. All staff have confirmed this was never mentioned to any of them whilst [Ms D] was away.

- I spoke to the GP clinic regarding this and he stated that when he came down, he noted how unwell [Mr C] was and instructed [RN E] to send [Mr C] to hospital ASAP. (See attached GP note).
- The hospital never contacted us to inform us of his passing, the only way we knew about this was when our [EN F] contacted the hospital on 12 Month2 2019 (see attached incident/accident form). [RN E] should have contacted the hospital either later that day, or the next day, this did not happen.
- Staffing at this time was not an issue (see rosters and time sheets), there was abundant staff, and also the clinical lead in [the first care home] was only a phone call away, also [RN E] could have contacted the EN to come to Morrinsville to help.
- The EN and I have audited the rosters from … 2019 through until … 2020, and we have found that staffing throughout that time was more than sufficient and was over the requirements that the ARC contract stated.
- I contacted [RN E] in … 2020 to discuss this complaint and for her to possibly meet with me to have a discussion, she agreed to [meet] me … This conversation was had in the admission office with [Ms J] present, she stated to me that she had spoken to the family and they had no further concerns. She then contacted me back saying she could not meet with me on this date as she needed to talk to her lawyer.'