Aria Park Senior Living Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 16HDC01467)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. Mrs A was a resident at a retirement village which is owned and operated by Aria Park Senior Living Limited (APSLL), which is part of a retirement village company.

2. In 2016, (Day 1[1]) it was first identified that Mrs A was experiencing difficulty in standing. It was found in the retirement village's internal review that at some time between 7am and 10am on Day 1, Mrs A had an unwitnessed fall that was not reported. However, the timing of this incident is disputed by Mrs A's family. There was a delay in caregivers informing nursing staff of the change in Mrs A's condition, and no incident report was completed.

3. On Day 2, Mrs A complained of right leg pain and later right arm pain. A registered nurse noted that Mrs A was for review by a doctor, but the doctor was not asked to see Mrs A that day.

4. On Day 3, two caregivers were using a transfer belt to move Mrs A as she was unable to stand unassisted and weight bear. During the transfer, the belt unclipped and Mrs A lost her balance and was lowered to the ground. Following this incident, Mrs A's pain escalated. At 1pm she was seen by a GP, who noted that she had trauma to the elbow, pain on movement of her right leg, and a tender knee. The GP recommended that Mrs A be taken to hospital for further investigation.

5. An ambulance was called at 4.15pm and Mrs A was taken to hospital, where she had X-rays of all affected areas and was diagnosed with a left elbow fracture. Mrs A was transferred back to the retirement village at 8.30pm, with instructions to continue her regular pain relief regimen; however, this did not occur.

6. Mrs A's pain became worse over the following days, and she was taken to hospital again by ambulance at 3pm on Day 5. Mrs A remained in hospital, and a CT scan undertaken on Day 9 showed pubic rami fractures that had not been visible via X-ray, and a torn rotator cuff and soft tissue injury to the right shoulder. Sadly, Mrs A's condition deteriorated and she died.

Findings

7. It was found that there were serious issues with the care Mrs A received at APSLL from multiple different staff members. In particular:

   a) There was a delay in Mrs A being seen by the GP once her change in condition was known by nursing staff, and there was no update to Mrs A's care plan in light of her changed mobility.

   b) The assessment of Mrs A's level of pain was lacking on Day 1 and Day 2, and there were multiple issues with her medication regimen.

[1] Relevant dates are referred to as Days 1-9 to protect privacy.

c) The change in Mrs A's condition was not documented appropriately on an incident form by any staff on Day 1 or Day 2, and the initial fall was not disclosed or reported by any staff members.

d) There was a three-hour delay between the GP review recommending transfer to hospital, and the ambulance being called to take Mrs A to hospital.

e) There were deficiencies in multiple aspects of APSLL's documentation of Mrs A's care.

f) When Mrs A was lifted off the floor, the two caregivers failed to use a full body hoist in accordance with APSLL's manual handling policy.

g) The communication with Mrs A's family about their concerns, and Mrs A's condition, should have been managed better.

8. In light of these issues, it was found that the care provided to Mrs A by the retirement village was inadequate. Accordingly, it was found that Aria Park Senior Living Ltd did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

9. The Deputy Commissioner is satisfied that there have been positive changes made to the service provided at the retirement village since these events.

Recommendations

10. The Deputy Commissioner recommended that APSLL report to HDC on further education provided to its staff, and improvements to its service in the areas of medication administration documentation; the process to support the use of restraint and restraint use documentation; incident reporting; and the process of seeking medical attention and transferring a resident's care to a secondary/tertiary hospital.

11. The Deputy Commissioner also recommended that APSLL use an anonymised version of this report as a case study to provide continuing education to caregiving and nursing staff at the retirement village, and provide a written apology to Mrs A's family.

Complaint and investigation

12. The Office of the Coroner forwarded a complaint to the Commissioner from Mr B regarding the services provided to his late mother, Mrs A, by Aria Park Senior Living Limited. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mrs A by Aria Park Senior Living Limited between Day 1 and Day 5 2016.*

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

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

14. The parties directly involved in the investigation were:

Mr B	Complainant
Aria Park Senior Living Ltd	Provider

Also mentioned in this report:

RN C	Clinical manager
RN D	Registered nurse
RN E	Registered nurse
Dr F	General practitioner
RN G	Registered nurse

15. Further information was received from:

The Coroner
Ambulance service
District Health Board
Medical Centre
HealthCERT

16. Independent expert advice was obtained from Registered Nurse (RN) Anna Blackwell, and is included as Appendix A.

Information gathered during investigation

Introduction

17. Mrs A was a resident at the retirement village from 2010. The retirement village is owned and operated by Aria Park Senior Living Limited (APSLL), which is part of the retirement village company. In 2014, Mrs A was assessed as requiring private hospital-level care owing to her increased frailty. She was transferred to the hospital-level care unit.

18. Mrs A was not taking regular pain medications, but had been prescribed the following pain medications on an "as needed" (PRN) basis: morphine 1mg/ml, Sevredol 10mg, paracetamol 1g three times daily, and codeine 15mg four times daily.

19. According to Mrs A's care plan, she required the assistance of one caregiver for all activities of daily living, including showering/personal hygiene, dressing and undressing, and oral hygiene.

20. Mrs A required the assistance of one caregiver when transferring to and from bed, commode, or wheelchair. Prior to Day 1, Mrs A could stand, with the assistance of one caregiver using a transfer belt, while holding on to a walker for stability.[3] Mrs A could also walk a short distance (15–20 metres) with the use of a walker and the assistance of a caregiver, and this activity was part of her usual daily routine. Mrs A's family described her as "active and lively".

21. Mrs A was turned by staff while she was in bed, and bedrails were used on both sides of her bed for safety.

22. There was an enduring power of attorney (EPA) for Mrs A's welfare held by Mrs A's daughter, and an EPA for property held by Mrs A's son.[4] The resident lifestyle support plan stated that Mrs A's family could be called at any time.

23. At the time of these events, RN C was the Clinical Manager. RN C worked 8am–5pm on Monday to Friday (inclusive). Multiple staff cared for Mrs A from Day 1–Day 5, including nurses, bureau nurses, and caregivers.

Background

Day 1

24. On Day 1, it was first identified that Mrs A was experiencing difficulty in standing. It was found in the retirement village's internal review (detailed further below) that at some time between 7am and 10am on Day 1, Mrs A had an unwitnessed fall that was not reported.

25. Progress notes made by a caregiver on Day 1 state: "[Mrs A complained of] pain on her right leg, couldn't stand properly, asked for another [caregiver] to help stand her up with lifting belt, inform RN otherwise no change."

26. No time is documented against these notes. The internal investigation found that the caregiver who came to assist was another caregiver. It was also determined that the caregivers were aware of the change in Mrs A's condition (i.e., being unable to stand) at about 10am, and that the notes were written at approximately 12.30–1pm. Mrs A was transferred by the caregivers to her recliner chair and wheeled to the lounge.

27. RN D was not informed by the caregivers of the change in Mrs A's condition until approximately 2pm. At that time, RN D administered Mrs A 20ml of liquid paracetamol for pain relief. No further complaints of pain were documented in the clinical records on this date. No incident report was completed in respect of Mrs A's changed condition, and there is no record of a physical assessment of Mrs A or the efficacy of the pain relief.

28. In response to the provisional opinion, Mr B told HDC that he visited his mother from 5pm to 8pm on Day 1. He said that she was fine and her usual self, was using a spoon in her

[3] Previously Mrs A had required two-person assistance for mobilising; however, the care plan was updated on 19 January 2016, stating: "[R]eviewed, [Mrs A] is no longer bed bound and chair bound, she is mobilised with … assistance of 1 staff."

[4] It is not clear from the records whether these were activated.

right hand to feed herself, and did not react when he touched her right arm. Mr B said that he was told by a caregiver that Mrs A had done a circuit on her walker that morning, and at no time during his visit was he told about a fall or any change in his mother's mobility.

Day 2

29. At 3.40am on Day 2, Mrs A complained of right leg pain, and 1g paracetamol was administered by RN E. RN E told management after the event that she had noticed that Mrs A's hip was swollen. RN E described the swelling as a protrusion on the right outer thigh, but did not document the swelling or the details of it, and no incident report was completed. There is no record of a physical assessment of Mrs A or the efficacy of the pain relief.

30. It is documented in the progress notes that at 9.30am, Mrs A complained of pain in her right arm, and a bruise was present. A Bureau RN gave Mrs A 1g paracetamol for pain and applied arnica to her arm. The RN documented that Mrs A had a swollen arm, and recorded "Dr Review". However, the doctor was not asked to see Mrs A that day. In response to the information gathered, Mrs A's daughter advised that she first found the bruise and reported this to the nurse at 11.45am.

Day 3

31. On Day 3 at 9.45am, two caregivers were using a transfer belt to transfer Mrs A from the commode to her recliner chair, as Mrs A was unable to stand unassisted and weight bear. It was reported that during the transfer the transfer belt unclipped, and Mrs A lost her balance and was lowered to the ground by the caregivers. This incident was documented in an incident report. The caregivers did not use a full body hoist as per the manual handling policy.

32. Following this incident, Mrs A's pain escalated. Mrs A complained of pain in her right arm, and it was noted that bruising extended from her right elbow down to the middle of her right lower hand. Paracetamol was given by RN D at 12.30pm, and an incident report documenting the bruise was completed.

33. General Practitioner (GP) Dr F saw Mrs A during his medical rounds at approximately 1pm. Dr F told HDC that there was no recorded or known history of a fall or accident at that time, but that his findings suggested some form of trauma to the elbow and probably the right leg/hip. He noted that obtaining history and examination was difficult owing to Mrs A's "severe dementia". Dr F documented in his notes that Mrs A had bruising to her right forearm, and pain on very slight movement of the right leg, and that her knee was also very tender. He recommended that Mrs A be taken to the Emergency Department at the public hospital for review and X-rays. In response to the information gathered, Mr B stated that Mrs A did not have severe dementia. He said that she required a starter to recall her short-term memory, and that was it.

34. Mrs A's daughter was telephoned at 3.10pm to update her about Mrs A's condition. As Mrs A's daughter was not available, a message was left with her son (Mrs A's grandson).

35. It is documented in the progress notes that at 1pm an ambulance was called to take Mrs A to hospital. However, the electronic ambulance service care summary, which states the time at which the call was placed to the call centre, confirms that the call was made at 4.15pm. The call was placed by RN D. Mrs A was transferred to the public hospital by ambulance at around 5pm. The ambulance care summary notes that Mrs A had had decreased mobility for three days, with "increased pain on [right] elbow and [right] hip/leg". The ambulance records also include a copy of Dr F's notes.

36. The public hospital's admission note states:

> "… ? unwitnessed fall [3 days] ago, presents with [3 days] of diffuse right sided pain ? Shoulder, hip, knee, decreasing mobility, bruising to right shoulder, right elbow, right lower limb. Patient is normally cognitively impaired. Sent in by GP."

37. Mrs A was diagnosed with a right elbow fracture. It was documented in the public hospital's notes that affected areas had been X-rayed, and no other bone changes were seen. Mrs A's arm was placed in a sling, as it was felt that she would not be able to tolerate a cast. It was also noted that on musculoskeletal examination Mrs A had diffuse hip and knee pain with mild contusions, and "decreased [range of movement] due to ? pain of all affected limbs vs resistance to movement".

38. At approximately 8.30pm on Day 3, Mrs A was transferred back to the retirement village with instructions to continue her pain relief regimen (Sevredol 10mg QID (four times a day) and paracetamol 1g TID (three times a day)). Mrs A's son spoke to RN G, raising concerns that his mother had sustained a fracture. RN G contacted the Clinical Manager, RN C, to advise her of Mrs A's fracture and Mr B's concerns.

39. RN C then attended the retirement village to receive Mrs A back from hospital.

40. Mrs A was not administered Sevredol after returning from the public hospital, and did not receive paracetamol regularly.

Day 4

41. Overnight on Day 3–Day 4, RN H commenced a pain assessment chart and a short-term care plan for the management of Mrs A's elbow.

42. The pain assessment chart notes that Mrs A was given medication at 5am with good effect; however, the medication given is not recorded anywhere.

43. Over the next 24 hours, Mrs A became agitated, and her pain could not be managed adequately.

Day 5

44. Mrs A was given paracetamol at 1.30am and morphine at 6am for pain relief. On the morning shift, her pain was scored as 7/10.

45. Mrs A's family visited her at approximately 11am and raised concerns about why she was not in her chair. Mrs A was given further morphine for pain, and transferred to her chair.

46. Mr B contacted RN C because he was concerned about his mother's level of pain. RN C then contacted RN G and instructed him to have Mrs A readmitted to hospital.

47. On Day 5 at 3pm, Mrs A was transferred via ambulance to the public hospital for further assessment of her pain. It was noted that she presented with right-sided pain and an inwardly rotated right hip/leg, as well as pain/bruising of her right shoulder and elbow.

Further events

48. A CT scan undertaken at the public hospital on Day 9 showed that Mrs A had pubic rami (pelvic) fractures that had not been visible via X-ray, and an X-ray showed a torn rotator cuff and soft tissue injury in the right shoulder. Mrs A's condition deteriorated, and, sadly, she died.

49. The Coroner advised HDC that Mrs A died of natural causes with left lower lobe pneumonia and left ventricular failure, and that the injuries sustained from her falls most likely contributed to her death.

Medication documentation

50. There were instances where the documentation of the medication Mrs A received was inconsistent. For example, on Day 1, the paracetamol given at 2pm was documented in the progress notes but not in the medication administration record; on Day 3, the medication administration chart states that 750mg paracetamol was given, but the progress notes state that 1g was given; analgesia was documented in the pain assessment chart as being given on Day 4 at 5am, but this is not recorded in the medication administration record, so it is not known what medication or dose was given.

Internal investigation

51. An internal investigation was carried out by the General Manager of Operations, the Clinical Manager, and the Village Manager. Twenty-two staff members were interviewed.

52. The Village Manager stated that despite extensive interviews, the investigation was unable to determine exactly how Mrs A sustained her injuries or who was involved, and was unable to address the non-disclosure of what happened. The Village Manager stated that the two caregivers who were looking after Mrs A on the morning of Day 1 made a number of statements that conflicted with one another, or were subsequently disproved by other staff.

53. The internal investigation made the following findings:

1. Mrs A had an unreported fall on Day 1. As a result, the appropriate assessment, pain management, and referral did not take place in a timely manner.
2. It is unclear whether Mrs A's bedrail was in place, as required by the restraint policy and restraint register documentation.

3. The locking mechanism for Mrs A's bedrail was broken, and had been for some time. However, the bedrail remained in place when upright. The bedrail could be lowered with reasonable pressure.
4. The caregivers caring for Mrs A on the morning of Day 1 did not report issues regarding the change in her condition until 2pm.
5. There was no formal assessment completed by the registered nurse at 2pm. This should have included a full mobility review, pain assessment, and initiation of a pain monitoring chart. It also would have been prudent to seek GP review at this time.
6. There was a lack of monitoring, recording, and management of pain from Day 1–Day 3 by the four registered nurses in charge of Mrs A's care at this time.
7. There was inadequate reporting at handover from one shift to the next.
8. There was a delay in referring Mrs A to the GP.
9. The two caregivers lifted Mrs A off the floor after the transfer belt failed, without a registered nurse assessment, and did not use a hoist according to policy/procedure when lifting someone from the floor.

Corrective actions

54. The following corrective actions were taken as a result of these events and the internal investigation:

Forms reviewed:

- A new handover template was put in place to allow space for each shift to document changes in residents' needs and communicate these to the following shift.
- The pain assessment form and monitoring charts were reviewed. No changes were made to these documents but nurses were given education on how and when to use them.
- A post-fall assessment form was put in place and is required to be completed after every fall.

Training:

- Nurses were given training on how and when to use a short-term care plan.
- Nurses were given training on pain identification and management.
- All staff attended eight hours of training on safe moving and handling.
- Nurses and caregivers were given further training on documentation. This focused on the importance of timely and accurate documentation, including short-term care plans, pain monitoring, incident and accident documentation and investigation, and post-falls monitoring.
- Caregivers are to receive training on accurate completion of progress notes, including documenting issues to be handed over to nurses.
- Nurses were given training on how to audit a care file, and then all resident files were audited.

- Training was provided by the Nationwide Health and Disability Advocacy Service on advocacy and the Code of Health and Disability Services Consumers' Rights (the Code).
- Training was provided on informed consent and open disclosure.

Staff:

- In total, three staff were suspended during the internal investigation and dismissed for misconduct. Six staff were given final written warnings.
- The number of clinical leaders has increased from two to three across the facility.
- The retirement village has partnered with an English Language School to assist staff who have English as a second language to gain a higher level of verbal and written communication.

Other:

- The faulty bedrail used on Mrs A's bed was removed from service immediately.
- A full audit of bedrails and locking mechanisms was completed on 20 June 2016.
- The transfer belt that failed was removed and replaced immediately.
- Monthly falls and restraint meetings have commenced.
- All incident reports are given to the Clinical Manager and Village Manager daily for review and prompt investigation.
- Appropriate and timely action is taken when poor practice is identified.

Further information

55. In 2015, the retirement village was purchased by a retirement village company, and is owned and operated by APSLL as part of the company. Staff remained in place at the time of acquisition. The Village Manager advised that a number of concerns regarding the management, systems, processes, and culture of care at the retirement village were raised relatively early in the new company's tenure. The incoming General Manager of Operations undertook a review of the clinical governance structure, the clinical processes and procedures, care planning practices, staff management, leadership and accountability, resident welfare, and the complaints procedure. This culminated in the appointment of an experienced interim Village Manager, and, subsequently, a new permanent Village Manager.

56. The Village Manager stated:

> "It is accepted that [management] held the overall responsibility for the care of residents at the retirement village. However, in this case, management were unaware of the concerns being raised in relation to [Mrs A] until [Day 3]. It was on this day that the Clinical Manager was first made aware of the concerns following [Mrs A's] discharge from [hospital] where [Mrs A] was diagnosed with a fractured right olecranon [elbow]. The Clinical Manager came immediately on site that evening to receive [Mrs A] back from Hospital to commence an investigation into the possible cause of the fracture. Her concerns were immediately escalated to the Village Manager and the GM Operations at [the retirement village company]."

57. The Village Manager stated that the registered nurses did not apply the expected standard of care in relation to documentation, medication administration, assessments, and pain management. He stated that the retirement village company believes that this was because of a generally "laissez-faire" culture at the retirement village, which was being addressed.

58. The Village Manager said that the retirement village company believes that the pervading culture at the retirement village contributed to the failure to disclose the original incident. He stated:

> "[W]e were saddened that our staff culture at the time was not one of openness and transparency and that, as a result, the care provided to [Mrs A] did not reflect the high standards we expect of our teams."

Surveillance audit

59. RN C notified HealthCERT that on Day 1 Mrs A had fallen and sustained injuries in an unreported incident. HealthCERT undertook an unannounced surveillance audit at the retirement village in 2017. All standards were attained, with the exception of one standard being partially attained (low risk) — this related to staff appraisals.

Responses to provisional opinion

60. APSLL was given an opportunity to respond to the provisional opinion. APSLL had no comments to make and acknowledged the Deputy Commissioner's provisional findings, recommendations, and follow-up actions.

61. Mrs A's family were given an opportunity to respond to the information gathered section of the provisional opinion. They raised concern that the care provided to Mrs A became worse following the ownership and management change in 2015, and stated that they have no complaints about the care provided to their mother prior to the ownership change. Mrs A's family are concerned about the methods used in the APSLL internal investigation, and consider the scenario to be a fabrication of what happened to their mother.

62. Mrs A's family dispute the timing of Mrs A's alleged unwitnessed fall. They advise that she did not present with any injury at all on the evening of Day 1 and consider that the fall must have occurred between 8pm on Day 1 and 3.40am on Day 2.

63. Mrs A's daughter recalls being told that Mrs A's bedrail had been replaced two weeks prior to the incident(s).

Opinion: Aria Park Senior Living Limited — breach

Introduction

64. APSLL had a duty to provide Mrs A services with reasonable care and skill. This included responsibility for the actions of its staff, and an organisational duty to facilitate continuity of care. APSLL also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

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

65. There were several deficiencies in the care provided to Mrs A by multiple different staff at the retirement village between Day 1 and Day 5. In my view, APSLL bears overall responsibility for these deficiencies.

66. I acknowledge that Mrs A's family and APSLL have different accounts of the timing of events during Mrs A's care, particularly her unwitnessed fall. In the circumstances I am unable to make a finding as to when this occurred.

Delay in obtaining GP review

67. Nursing staff were first informed that Mrs A's condition had changed (i.e., she was unable to stand) at 2pm on Day 1. Mrs A was not seen by Dr F until his usual round two days later, on Day 3.

68. My aged care nursing advisor, RN Anna Blackwell, noted that there was no updated entry in Mrs A's lifestyle plan, or a short-term care plan implemented to guide staff in relation to Mrs A's change in mobility. RN Blackwell stated that when a resident is not a good historian and there is no evidence of trauma, it is not unusual to monitor the person closely and offer regular pain relief for a short period of time. When there is no improvement, it is best practice to have the resident reviewed by the GP. RN Blackwell commented that the failure to do this was a deviation from the accepted standard of nursing care.

69. I accept RN Blackwell's advice. I am critical of the time it took for Mrs A to be seen by the GP once her change in condition was known by nursing staff, and also that Mrs A's care plan was not updated in light of her changed mobility.

Pain assessment and analgesia administration

70. On Day 1 and Day 2, Mrs A was administered paracetamol by several different nursing staff, with no physical assessment or efficacy of the medication recorded. RN Blackwell commented that it would be usual practice for a resident with a change in mobility to have a full physical assessment and pain assessment completed by a registered nurse prior to any analgesia being administered. RN Blackwell advised that the management of Mrs A's pain, medication, and change in mobility from Day 1 is a departure from the accepted standards of care.

71. RN Blackwell commented that Mrs A's analgesia was managed intermittently. RN Blackwell noted the following issues with Mrs A's analgesia regimen:

a) On two occasions (Day 1 and Day 4) medication was administered and recorded in the progress notes or pain assessment chart, but not in the medication administration record.

b) On Day 4, analgesia was noted to have been given with good effect, but it is not recorded what analgesia was given.

c) Prior to confirmation of the fractured elbow, Mrs A's analgesia was suboptimal with no planned approach.

d) After Mrs A returned to the retirement village from the public hospital with a confirmed elbow fracture, Mrs A was not commenced on regular pain relief (Sevredol and paracetamol) to provide a baseline.

72. RN Blackwell considers that the management of Mrs A's analgesia prior to confirmation of her fractured elbow was a departure from accepted standards, as was the management of her analgesia following confirmation of her fractured elbow.

73. I accept RN Blackwell's advice. I am concerned that Mrs A did not receive a full physical assessment, that assessment of Mrs A's level of pain was lacking on Day 1 and Day 2, and that there were multiple issues with her medication regimen and pain management, as outlined above. It is particularly concerning that prior to confirmation of Mrs A's elbow fracture there was no planned approach to her pain management, and that following this confirmation she was not administered Sevredol or regular paracetamol in line with the discharge summary recommendation.

Incident reporting

74. The retirement village found that Mrs A had an unwitnessed fall on the morning of Day 1, but was unable to determine what happened despite extensive interviews with staff. An incident report was not completed on Day 1 in respect of this event or Mrs A's change of condition (i.e., her inability to weight bear). RN Blackwell considers that there was a lack of recognition by all staff of the change in Mrs A's condition, and commented that this led to a lack of incident forms being completed.

75. I agree with RN Blackwell's comments. I am concerned that the change in Mrs A's condition was not documented appropriately in an incident form by any staff on Day 1 or Day 2. I am also concerned that the fall was not disclosed or reported by any staff members, and I accept the Village Manager's explanation that the staff culture at the time of the event was not one of openness and transparency, which he believes contributed to this failure to disclose the incident.

Delay in ambulance contact

76. At 1pm on Day 3, Mrs A was seen by Dr F, who recommended that she be taken to the public hospital in light of the trauma to her elbow and her right leg/hip. However, a call to

the ambulance service to transfer Mrs A to the public hospital was not placed until 4.15pm. In my view, the ambulance service's electronic record of the call time is a more accurate reflection than the progress notes, which state that the call was placed at 1pm. RN Blackwell is critical that there was a three-hour delay in telephoning for an ambulance and preparing Mrs A for transfer to the public hospital. RN Blackwell commented that this represents a departure from accepted standards.

77. It is concerning that there was a three-hour delay between Dr F's review and recommendation of transfer to hospital, and the ambulance being called to take Mrs A to hospital. In my view, the delay was unnecessary, and no reason for it has been provided.

Documentation

78. RN Blackwell identified deficiencies in documentation at the retirement village, particularly in relation to medication administration and pain assessment, as well as a lack of care plans and incident reports. She also noted that there was an absence of restraint monitoring throughout the records. She advised that cumulatively, this represents a departure from accepted standards. I accept RN Blackwell's advice, and am critical that there were deficiencies in multiple aspects of APSLL's documentation of Mrs A's care.

Failure to comply with manual handling policy

79. On the morning of Day 3, two caregivers were using a transfer belt to assist Mrs A to the commode chair. The transfer belt failed, and Mrs A was lowered to the ground. When Mrs A was lifted off the floor, the two caregivers failed to use a full body hoist in accordance with APSLL's manual handling policy. I am concerned that a hoist was not used in this instance.

Communication with family

80. An EPA for welfare was held by Mrs A's daughter, and an EPA for property was held by Mrs A's son, and the resident lifestyle support plan stated that the family could be called at any time. RN Blackwell was critical of the level of communication with Mrs A's family. She advised that it would have been appropriate to offer to meet with Mrs A's family when she returned to the retirement village on Day 3. RN Blackwell commented that there was a greater need for a family meeting given that APSLL was aware that Mrs A's family were already disappointed with the care provided.

81. I accept RN Blackwell's advice, and consider that the communication with Mrs A's family about their concerns, and Mrs A's condition, should have been managed better.

Conclusion

82. In my view, APSLL had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code. Overall, there were serious issues with the care Mrs A received at APSLL from multiple different staff members. In particular:

a) There was a delay in Mrs A being seen by the GP once her change in condition was known by nursing staff, and there was no update to Mrs A's care plan in light of her changed mobility.

b) The assessment of Mrs A's level of pain was lacking on Day 1 and Day 2, and there were multiple issues with her medication regimen.

c) The change in Mrs A's condition was not documented appropriately on an incident form by any staff on Day 1 or Day 2, and the initial fall was not disclosed or reported by any staff members.

d) There was a three-hour delay between the GP review recommending transfer to hospital, and the ambulance being called to take Mrs A to hospital.

e) There were deficiencies in multiple aspects of APSLL's documentation of Mrs A's care.

f) When Mrs A was lifted off the floor, the two caregivers failed to use a full body hoist in accordance with APSLL's manual handling policy.

g) The communication with Mrs A's family about their concerns, and Mrs A's condition, should have been managed better.

83. In light of these issues, I consider that the care provided to Mrs A by the retirement village was inadequate. Accordingly, I find that Aria Park Senior Living Ltd did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Other comment — changes made at the retirement village

84. RN Blackwell made the following comment regarding the steps undertaken since this event:

> "[The retirement village has] responded in detail regarding the management of the individual staff members involved. I am satisfied their stated actions address all concerns raised … There has been a comprehensive undertaking to address all areas and learn from the events surrounding [Mrs A's] care management. There has been full acceptance by the team that improvements were needed. The increase in leadership staffing numbers, education programme, documentation systems, reporting and meetings structures implemented show an organisational commitment to learning from this event and to a quality improvement culture."

85. RN Blackwell also commented that she has no concerns about the adequacy of the policies and procedures at the retirement village at the time of these events or currently.

86. I accept RN Blackwell's advice. I am satisfied that there have been positive changes made to the service provided at the retirement village since these events.

Recommendations

87. Noting the time that has passed since these events, and the changes already implemented, I recommend that within three months of the date of this opinion, Aria Park Senior Living Ltd report to HDC on further education provided to its staff, and improvements to its service in the areas of medication administration documentation; the process to support the use of restraint and restraint use documentation; incident reporting; and the process of seeking medical attention and transferring a resident's care to a secondary/tertiary hospital. The report should be provided with a view to assuring HDC that the changes in place at the retirement village are working. In the event that I am not sufficiently confident that the recommendations have been met, I may make additional recommendations.

88. I recommend that Aria Park Senior Living Ltd use an anonymised version of this report as a case study to provide continuing education to caregiving and nursing staff.

89. I recommend that within three weeks of the date of this opinion, Aria Park Senior Living Ltd provide a written apology to Mrs A's family for the issues identified in this report. The apology should be provided to HDC for forwarding.

Follow-up actions

90. A copy of this report will be sent to the Coroner.

91. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Aria Park Senior Living Ltd, will be sent to HealthCERT and the district health board.

92. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Aria Park Senior Living Ltd, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Anna Blackwell:

"1 Disclaimer

I, Anna Celeste Blackwell, have been asked to provide an opinion to the Commissioner on case number C16HDC01467. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I have no known personal or professional conflict in this case.

2 Expert's Background

I have been a New Zealand Registered Nurse for twenty-eight years with a background in clinical and nursing management. I have a postgraduate diploma in nursing. I have attended education in quality, leadership and professional supervision. I have been a Career Force assessor for caregivers and diversional therapists. I have a strong background in nursing leadership having worked in Charge Nurse, Duty Nurse Manager, Facility Manager/GM and associate DON positions. I worked in the aged care sector for eight years managing facility, clinical, quality, HR and compliance. Currently I do consultancy and contract work in the health sector providing facilitation, training, leadership, advice and project management. I am a member of the College of Nurses Aotearoa, New Zealand Nurses Organisation, The NZ Aged Care Association and CQ.

3 Instructions from the Commissioner:

I have been asked to review the documentation sent to me and advise whether I consider the care provided to [Mrs A] was reasonable in the circumstances, and why. In particular the Commissioner has asked me to comment on:

<u>[Retirement village]</u>

3.1 The appropriateness of the Registered Nurse's (RN) decision to wait for [Mrs A] to be reviewed by the GP on [Day 2], rather than when it was known she was unable to stand on [Day 1].

3.2 The lack of formal assessment by the RN staff of [Mrs A's] mobility and pain between [Day 1]-[Day 3].

3.3 The appropriateness of analgesia administration between [Day 1]-[Day 3].

3.4 The lack of incident forms between [Day 1]-[Day 3].

3.5 The appropriateness of the RN's decision to advise the ambulance to use usual road speed when transferring her to [the public hospital] on [Day 3].

3.6 The standard of communication between [the retirement village] and [Mr B] and [his sister] regarding their mother's condition.

3.7 The overall standard of documentation by the RNs.

3.8 The remedial action taken by [the retirement village] and whether it is appropriate in the circumstances.

3.9 Any other matters you consider warrant comment.

For each question, I will advise:

- What is the standard of care/accepted practice?
- If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (i.e. mild, moderate or severe)?
- How would it be viewed by your peers?
- Recommendations for improvement that may help to prevent a similar occurrence in future.

If you note that there are different versions of events in the information provided, please provide your advice in the alternative. For example, whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

4 Sources of Information

Supplied by the HDC office:

- Referral letter from [the Coroner] to HDC dated 22 September 2016.
- [The retirement village's] response to the Coroner dated 12 July 2016.
- [The retirement village's] investigation report dated 25 July 2016.
- [Mr B's] response to [the] investigation report dated 25 August 2016.
- [The retirement village's] clinical documentation regarding [Mrs A].
- Undated response to HDC from [the] Village Manager.
- [Public Hospital Emergency Medicine Consultant's] statement to [the Coroner] dated 7 July 2016.
- [Public Hospital Consultant Geriatrician's] statement to [the Coroner] dated 26 July 2016.
- [Ambulance service] reports dated [Day 3] and [Day 5].
- [The retirement village] company's Restraint Minimisation and Safe Practice Policy and Procedure documents.

5 Factual Summary

[Mrs A] ([…] years old) was a resident at [the retirement village] [from 2010] until [Day 5]. [In] 2015, [Mrs A] was assessed as requiring private hospital level care due to increased frailty. She was transferred to the hospital level care unit at [the retirement village]. Her medical history included:

- CRF
- Glaucoma
- GORD
- COPD
- HTN
- NIDDM
- Pyelonephritis 2010
- Dementia
- Frozen shoulder
- MRSA

- IHD
- Mild aortic stenosis
- R) THJR 1979
- Previous hiatus hernia
- Vulvectomy

Over the period of [Days 1-3], [Mrs A] complained to [the retirement village] staff of pain in her right leg and then right arm. On [Day 1], it was first identified that [Mrs A] was experiencing difficulty in standing and liquid paracetamol was administered at 2.00pm.

On [Day 2] at 3.40am, [Mrs A] complained of right leg pain and paracetamol was administered. At 9.30am, [Mrs A] complained of pain in her right arm and it was noted that a bruise was present. Again, she was administered paracetamol for the pain.

On [Day 3], [Mrs A] complained of pain in her right arm and it was noted that the bruise extended from her right elbow down to the middle of her right hand. Paracetamol was given at 1.00pm and an incident form was completed. The same day, two caregivers were using a transfer belt to transfer [Mrs A] onto the commode chair. It was reported that the transfer belt unclipped during the transfer and [Mrs A] lost her balance and was lowered to the ground by the caregivers. Following this incident, [Mrs A's] pain escalated and she was transferred to [the public hospital].

[Mrs A] was diagnosed with a right elbow fracture and was treated with a sling as it was felt she would not be able to tolerate a cast. At 9.00pm on [Day 3], [Mrs A] was transferred back to [the retirement village]. Over the next 24 hours, [Mrs A] became agitated and her pain could not be adequately managed. On [Day 5] at 2.00pm, [Mrs A] was transferred to [the public hospital] for further assessment of her pain. A CT scan showed [Mrs A] had a fractured pelvis, a torn rotator cuff and soft tissue injury in the right shoulder. On [date], [Mrs A] died. [The Coroner] advised HDC that [Mrs A] died of natural causes with left lower lobe pneumonia and left ventricular failure, and that the fractures were most likely contributing factors.

6 Complaint

On 22 September 2016, [the Coroner] referred [Mr B's] concerns to HDC for assessment. Included in the referral was [Mr B's and his sister's] response (of 25 August 2016) to [the retirement village's] internal investigation. They have complained about the standard of care provided to their mother by [the retirement village]. [The Coroner] suggested that the family may also want to complain about [the public hospital]. The HDC's office have subsequently clarified this with [Mr B] and he does not wish to pursue a complaint about [the public hospital].

7 Expert Review

7.1 The appropriateness of the Registered Nurse's (RN) decision to wait for [Mr B] to be reviewed by the GP on [Day 2] rather than when it was known she was unable to stand on [Day 1].

Scenario A) It was documented on [Day 2] in the progress notes that [Mrs A's] arm was causing her pain and also recorded '... R) arm swollen (hematoma) Dr Review no concern'.

There is no record that shows a GP was called or saw [Mrs A] on [Day 2]. The progress notes indicated there was no GP review requested until 1300hrs on [Day 3] following a documented fall at 0945hrs.

B) During [the retirement village's] internal investigation it was recorded that [RN E] assessed [Mrs A] on [Day 1] at 1400hrs and administered Panadol Elixir 20mls. [RN E]'s decision to wait for medical review until the next regular GP round on [Day 3] (two days time, not the next day as stated in the investigation) is not supported by a documented clinical rationale. There was no updated entry in the Resident Lifestyle Care Plan or a Short term Care Plan to guide care staff around the change in mobility or what to report that would then require more immediate review.

When a resident is not a good historian and there is no evidence of trauma it is not unusual to monitor closely and offer regular pain relief for a short period of time. When there is no improvement it would be best practice to have the resident reviewed by the GP.

In both scenarios the RNs did not apply the expected[1] standard of care of a registered nurse and is a moderate to severe deviation.

7.2 The lack of formal assessment by the RN staff of [Mrs A's] mobility and pain between [Day 1]-[Day 3].

Prior to [Day 1] [Mrs A] required one person assist and could walk small distances with her walker with one person present to assist. On [Day 1] the first entry that indicates a change to [Mrs A's] condition was recorded. There was no time allocated to this entry and no designation of the staff member. The name of the person making this entry was not legible. The entry records that [Mrs A] was complaining of pain 'on' her right leg, couldn't stand properly and another health care assistant (HCA) helped to stand her up with a lifting belt. This progress note records that an RN was informed. It does not indicate what time the RN was notified or who that RN was.

On [Day 1] it was recorded in the progress notes at 1405hrs that Panadol elixir 20mls was given at 1400hrs. There was no designation recorded of the person making this entry and the signature is not legible. There was no record of this administration on the medication administration records. There was no clinical rationale for giving this 'as required' (PRN) medication nor was there a pain assessment or efficacy comment recorded.

There was no afternoon progress note written for [Day 1]. On the night shift, [Day 2], [RN E] documented in the progress notes administration of 1gm paracetamol as

[1] Nursing Council of New Zealand (NCNZ), Code of Conduct (Wellington: NCNZ, 2012).

charted at 0320 for pain 'on' [Mrs A's] R leg. On the medication administration record this dose was recorded as 1½ 500mg tabs (750mg). There is no physical assessment recorded by the RN and no efficacy comment recorded.

There were two entries in the progress notes for the morning of [Day 2]. The first entry was at 0930; this entry was not assigned a staff designation or have a legible name, I read it as a HCA entry. This entry documents [Mrs A] was complaining of pain in her right arm and notes a bruise on arm. This entry states [Mrs A] was given paracetamol and arnica cream was applied. It was recorded at 0930 — there was only one administration of Panadol recorded for the morning shift on [Day 2] and this was recorded at 1210hrs on the Medication Administration Chart.

The next documentation for the morning shift [Day 2] was at 1440hrs. This entry was not assigned a staff designation or have a legible name, I read it as a RN entry, based on its content and the Village Manager's report. This entry noted [Mrs A's] arm as '... R) arm swollen (hematoma) Dr Review no concern'.

It would be usual practice for a resident with a change in mobility, such as [Mrs A] was noted as having, on the morning shift of [Day 1] to have a full physical assessment and pain assessment completed by the Registered Nurse prior to any analgesia being administered. Depending on the findings this would be followed by a referral to the GP for review and notification to the NOK of the change in [Mrs A's] condition and a Short Term Care Plan (STCP) commenced as per [the retirement village's] policies. It would be usual practice in a hospital level facility that if the RN who delegated resident care to the HCA was unable to assess [Mrs A] the HCA staff would then report to another RN or the Clinical Leader for help.

The management of [Mrs A's] increase in pain, medication management and change in mobility from the [Day 1] is a severe departure from accepted standards of care.

7.3 The appropriateness of analgesia administration between [Day 1-Day 3].

I have reviewed the analgesia administration until the [Day 5] when [Mrs A] returned to the public hospital for pain management and further investigation.

[Mrs A's] analgesia was managed intermittently. There was no evidence of any pre-emptive analgesia and this continued after her return from the public hospital on [Day 3]. Table 1: Analgesia Administration to [Mrs A], outlines the analgesia administered across the period [Days 1-5]. The entries in [bold] indicate medication administered and recorded in the progress notes or pain assessment chart but not recorded in the medication administration record as per standards of practice.[2] There were two occasions, on [Day 2] that a lesser dose of 750mg was given instead of the Paracetamol 1gm as charted. There was no clinical rationale given for this change to the prescription.

[2] The Medicines Act (1981) and associated regulations; The Misuse of Drugs Act (1975) and associated regulations; Medicines Care Guides for Residential Aged Care, MOH (2011); Nursing Council of NZ Code of Conduct (2012).

On [Day 4] at 0500 the RN has documented in the pain assessment chart that [Mrs A] had a pain score of 3/10[3] [and] the chart has it recorded that analgesia is given with good effect. It does not record what the analgesia was. As an aside, if it was paracetamol that was given then the next dose given at 0800 would have been given within four hours, which is not recommended practice particularly in the frail elderly.

Date	Time	Medication	Dose	Indication	pain score	Efficacy	Reviewer's notes
[Day 1]	**1100**	**Paracetamol**	**1000mg**	**c/o pain R leg**	**x**	**x**	**recorded in progress notes**
[Day 2][r]	0320	Paracetamol	750mg	c/o pain R leg	x	x	
[Day 2]	1210	Paracetamol	1000mg	c/o pain R arm	x	x	
[Day 3]	0230	Paracetamol	1000mg	c/o pain R leg	x	x	
[Day 3]	0800	Paracetamol	1000mg	c/o pain R leg	x	x	
[Day 3]	1200	Paracetamol	750mg	x	x	x	
In the public hospital for review — returned late on the PM shift to [the retirement village]							
[Day 4]	**0500**	**?**	**?**	**pain R arm**	**3 ache**	**settled slowly:**	**recorded on Pain Assmt Chart**
[Day 4]	0830	Paracetamol	1000mg	pain R arm	5 very painful	good effect	
[Day 4]	1830	Morphine	2.5mg	pain R arm R knee	4 painful	good effect	
[Day 5]	0130	Paracetamol	1000mg	pain R arm R hip	3 severe pain	settled slowly	
[Day 5]	0600	Morphine	5mg	R side	5 severe pain	minimal effect	
[Day 5]	0800	Paracetamol	1000mg	R arm R hip	7	settled	
[Day 5]	1130	Morphine	5mg	son's request	x	transferred to chair	

Table 1: Analgesia administration to [Mrs A]

Prior to confirmation of fractured elbow I find [Mrs A's] analgesia management suboptimal with no planned approach. This can be explained by the absence of a full assessment and the realisation by staff that something more significant had occurred. [Mrs A] did receive analgesia when staff noted she reported pain, which in the absence of further documentation, appears to have settled her pain.

[The retirement village's] approach to managing [Mrs A's] PRN analgesia is a moderate departure to accepted standards and not in line with [the retirement village's] Pain Management Policy.

From [Day 3]–[Day 5] (after [Mrs A] returned from the ED) [Mrs A] was not commenced on any regular pain relief to provide a base line. It would be accepted practice both in the Aged Care sector and in the secondary care setting to have regular analgesia charted, with PRN analgesia for break through pain as back up. The goal of care would be to keep [Mrs A] pain free. The discharge note from [the] Emergency Dept included a management plan for [the retirement village]. It stated:

> *'[Day 3] 20:26 sling R elbow as tolerated. Given pt's age and cognitive status, would not tolerate cast or be a candidate for surgery. Will sling right arm, continue pain regimen at home (on sevredol 10mg QID and Paracetamol 1g TID), and have GP at care home assess ongoing need for pain meds.'*

[3] 3–5 being moderate on the retirement village pain score key.

[Mrs A] was not given sevredol ever or paracetamol regularly. There is no evidence the GP was asked to review her or her medications on [Day 4]. The STCP omits instructions for regular pain relief to be charted or given from the PRN chart. [Mrs A] was reported to be complaining of pain in both her arm and leg across [Day 4] and [Day 5]. The pain assessment chart instructions state it is to be completed at least 4 hourly and for at least 24 hours and to continue to record pain in the chart until there are no further episodes of pain.[4] On [Day 4] there was a pain assessment recorded at 0830hrs stating severe pain, the next pain assessment was recorded, 9.5 hours later, at 1800hrs. On [Day 5] there was four hourly pain assessments recorded during the night shift. There were no entries on the pain assessment chart for the day shift. The ambulance was called for [Mrs A] at 1407hrs [Day 5].

I am critical of the management of [Mrs A's] pain once the staff knew she had a fractured elbow and tissue damage to her hip and leg. This is a severe departure from accepted standards of pain management and unacceptable nursing care.

I would recommend [the retirement village] include more information in the clinical guideline and provide education addressing management of acute pain and principles for managing orthopaedic injuries conservatively, including limb alignment, change of position and pressure relieving mattresses.

7.4 The lack of incident forms between [Day 1]-[Day 3].

The lack of recognition by all staff: health care assistants, registered nurses and the clinical management staff that [Mrs A's] condition had changed significantly contributed to the lack of incident forms completed. Across six shifts with different care staff and RNs, [Mrs A's] acute pain and decrease in mobility was not linked and therefore no incident forms were recognised as being needed.

This is not accepted practice and I consider it to be a moderate departure.

I regard the documented fall from the lifting belt on the morning of [Day 3] to be secondary to the original event where [Mrs A] received her injuries on either the night shift or morning shift of [Day 1]. The second event may or may not have aggravated her injuries. This incident was documented as occurring at 0945 and an incident (FLASH) form was completed at the time. Family were not contacted until 1300hrs which would not be considered best practice.

I would recommend undertaking education in advocacy and open disclosure for all staff.

7.5 The appropriateness of the RN's decision to advise the ambulance to use usual road speed when transferring her to [the public hospital] on [Day 3].

The entry in the progress notes indicated the ambulance was called at 1300hrs [Day 3]. The village manager's response (undated) to the HDC pg2, states '... it was

[4] Pain Assessment Chart 2015.

ascertained that the ambulance was called between handover of the morning shift to the afternoon shift between 3–3.15pm'.

My review of the Ambulance Care Summary reports provided for [Mrs A's] two transfers to [the public hospital] by [the ambulance service] provides the time the call was placed to the call centre and the time the ambulance crew arrived on site.

On [Day 3] the ambulance call was placed at 1615hrs and the ambulance was on site at 1625hrs (10 minutes). The ambulance left [the] Resthome at 1655hrs and arrived at [the public hospital] at 1713hrs.

It would be accepted practice, for this type of transfer, for the ambulance to come at road speed rather than with the sirens on. The delay in the ambulance arrival was caused by [the retirement village's] delay in placing the call, not the speed at which the ambulance travelled.

[Mrs A's] level of discomfort, the duration and unknown cause would warrant more urgency than was given. There was a three-hour lapse between preparing for hospital admission and phoning for an ambulance. I consider this to be a moderate to severe departure in accepted standards.

I would recommend [the retirement village] review their protocols for hospital transfer so that the necessary help is made available when a RN has to reallocate work to ensure timely transfer of residents for acute care.

7.6 The standard of communication between [the retirement village] and [Mrs A's son and daughter] regarding their mother's condition.

[Mrs A] had been a resident at this facility for five years, nine months. Usually when a resident has that length of stay the clinical staff and leadership staff are not only familiar with the normal patterns of behaviour and care for the resident but also the involvement and expectations of the family. It would have been accepted practice for the staff to update [Mrs A's daughter] when she visited on the morning of [Day 2] that her mother wasn't mobilising well and had been complaining of pain in her arm and leg over the previous 24 hours. It would not be unusual for the caregivers to have this conversation in their interaction with [her] when she visited.

When [Mrs A] returned with her fractured elbow (olecranon) [the retirement village] were aware the family were not happy with their mother's care and also that an event had taken place either on the night shift of [Day 1] or the dayshift of [Day 1]. Resident and family centred practice would be to invite the son and daughter to attend a meeting and set out what was known and then agree on the plan of care going forward, namely what the family would like to be notified of and what were the family's expectations of care. Partnership is one of the values expressed as underpinning professional conduct[5] for nurses' calls.

[5] Nursing Council of New Zealand (NCNZ), Code of Conduct (Wellington: NCNZ, 2012).

[The retirement village's] level of communication with the family was suboptimal and a moderate departure from accepted standards of practice.

7.7 The overall standard of documentation by the RNs.

The standard of documentation has been discussed above. I note from [the retirement village's] remedial actions there has been training on documentation for registered staff and care givers. Progress notes were not allocated designations, times were not accurate between reporting and medication administration.[6]

Medication administration documentation was not accurately reflected in the progress notes. The progress notes did not follow from one shift to another.

The short term care plan (STCP) written on [Day 4] when [Mrs A] returned from [the public hospital] does not provide a goal oriented plan to manage [Mrs A's] conservative treatment. It would be usual practice for a RN to document a clear management plan for HCAs and RNs to follow and report against. Setting timeframes for pain assessment, commencing a regular analgesic regime for [Mrs A] to manage her level of comfort would be expected. It is good practice to include information for the carers as to positioning and correct application of a sling. I am critical of the standard of the STCP written for [Mrs A].

I also note that most of the policies supplied by [the retirement village] for this investigation have review dates of 2015.

The overall quality of the documentation by the RNs is poor and is a severe departure from required nursing standards.[7]

7.8 The remedial action taken by [the retirement village] and whether it is appropriate in the circumstances.

[The retirement village] undertook a review of its care of [Mrs A] and implemented a comprehensive education plan and document review to address all concerns raised.

This included education regarding:

- Manual handling training
- Incident and accident reporting
- Documentation
- Use of STCP
- Communication
- Pain Management

There is also supplied evidence of improvements in handover procedures and work being done to encourage a positive and open facility culture.

[6] Ensure any entries you make in health consumer's records are clearly and legibly signed, dated and timed. (Nursing Council of NZ Code of Conduct pg6).
[7] Nursing Council of New Zealand (NCNZ), Code of Conduct (Wellington: NCNZ, 2012).

Health Care Assistants and RNs need to be thoroughly aware of the communication channels and who to report concerns to, how to document those concerns and how to escalate if the 'floor staff' are too busy to attend. The clinical manager needs to have systems and routines in place to ensure her ability to know which residents the staff need support with.

This remedial action has covered many issues raised in reviewing [Mrs A's] care. It would be enhanced by including education in advocacy, open disclosure, supervision and delegation, medication management, acute vs chronic pain and Nursing Council Code of Conduct requirements for RNs.

7.9 Any other matters you consider warrant comment.

Further to the standard of documentation I have already covered I do have concerns regarding the absence of any restraint monitoring throughout the clinical notes. [Mrs A's] restraint documents were last reviewed [in the month before her fall] indicating current restraint in place and required — these being bedrails. I could see no instructions or reference to this restraint in her lifestyle care plan or in the progress notes and no monitoring documented.

I also note in the Village Manager's letter to the Coroner's office (dated 12/7/16) page 4, paragraph 2 that following [Mrs A's] witnessed fall she was '… seated on her fallout chair'. I can find no restraint documentation to support the use of a fallout chair in the notes provided.

I would recommend [the retirement village] also review their compliance against their restraint minimisation and safe practice procedures."

The following further advice was received from RN Blackwell:

"Thank you for the opportunity to review the remedial actions undertaken by [the retirement village] and provide further advise to the Commissioner on this case.

I have read and reviewed all documents supplied to me by your office as follows:

- Rosters
- Interview statements
- Manual handling policy
- incident policy (former)
- incident policy (current)
- staff training records
- part 2 staff training records
- part 3 staff training records
- clinical manager position description
- RN position description
- caregiver position description
- pain management policy (current)

- care plan
- falls management policy (former)
- medication policy (current)
- pain management policy (old)
- falls prevention and management policy (current)
- restraint evaluation and assessment
- restraint monitoring
- ARC agreement

I have been asked to comment on:

1. The standard of care provided by any individual nursing staff if you consider this warrants comment.
2. The adequacy of the policies and procedures in place at the time of the events complained about ([Day 1-5]) as well as currently.
3. The appropriateness of any remedial measures undertaken by [the retirement village].

Any other matters in this case you consider warrant comment.

Review:

1. <u>The standard of care provided by any individual nursing staff if you consider this warrants comment.</u>

[The retirement village] [has] responded in detail regarding the management of the individual staff members involved. I am satisfied their stated actions address all concerns raised. There is a comprehensive education programme implemented that addresses all concerns identified. While not supplied it would be reasonable to expect there are performance plans in place for [three of the RNs] to ensure their practice is monitored and re evaluated by [the] Clinical Management team against Nursing Council Practice Standards.

I note [RN E] resigned from [the retirement village]. Mandatory reporting requirements to the NZ Nursing Council states:

> *An employer **must** notify the Council when a nurse has resigned or been dismissed for reasons relating to competence. A notification must also be made to the Council by the Health and Disability Commissioner or the Director of Proceedings if he or she believes that a nurse poses a risk of harm to the public by practising below the required standard of competence.*[8] *(pg 1 Health Practitioners Competence Assurance Act 2003 Competence Review Process).*

I would recommend this notification occur if it hasn't already.

[8] http://www.nursingcouncil.org.nz/Publications/Nursing-health-and-fitness-to-practise.

2. <u>The adequacy of the policies and procedures in place at the time of the events complained about ([Day 1- 5]) as well as currently.</u>

[The retirement village] had recently been purchased by [the retirement village copmany]. They have explained they were updating all policies and procedures to the [new company's] templates. The policies not being adhered to whether previous or new is the agreed issue. The DAA surveillance audit on 18 January 2017 reports Full Attainment for [the retirement village] against all the standards pertaining to documentation and policies and procedures.

The current Medication Policy has a combination of processes for hard copy medication management and also refers to using medimap (an electronic medication administration system). It is unclear whether [the retirement village] is using Medimap or not — I would recommend clarifying this at the beginning of the policy.

I have no concerns regarding the adequacy of the policies and procedures reviewed.

3. <u>The appropriateness of any remedial measures undertaken by [the retirement village].</u>

Having fully reviewed all of the above stated information supplied by [the retirement village] in response to my advice to the Commissioner dated 24 May 2017 there has been a comprehensive undertaking to address all areas and learn from the events surrounding [Mrs A's] care management. There has been full acceptance by the team that improvements were needed. The increase in leadership staffing numbers, education programme, documentation systems, reporting and meetings structures implemented show an organisational commitment to learning from this event and to a quality improvement culture.

Noteworthy is the inclusion of the English as a second language training partnership to support RNs with their written and verbal communication skills. This is a commendable initiative given the high number of staff this involves and the impact for residents and organisations when this is suboptimal."