Beta Pacifica Corporation Limited
Registered Nurse, Mr C

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC01197)

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Executive summary

1. In 2009, Mrs A, aged 81 years, was admitted to a rest home for rest home level care. The rest home was owned by Beta Pacifica Corporation Limited (Beta Pacifica). Mrs A had multiple co-morbidities, including chronic obstructive pulmonary disease (COPD) and ischaemic heart disease, and was taking multiple medications.

2. RN C was an inexperienced graduate nurse. In mid 2011 he was employed by Beta Pacifica as a registered nurse (RN) to cover RN duties at the rest home and another facility. He was employed under the supervision of a Clinical Services Manager, who was also an RN, for about three months. The following month the Clinical Services Manager resigned, and no subsequent arrangements were made to find a replacement. RN C said that he registered his concerns with management that, for a period of time, he was left to cover RN duties at two facilities without clinical supervision.

3. On Day 1[1], Mrs A developed a cough and was losing her voice. On Day 4, RN C became aware of Mrs A's changing health status. She was not feeling well, and did not want to eat. No short-term care plan was put in place to inform the caregivers of any monitoring or interventions required.

4. On Day 6, RN C recorded some basic observations, including that Mrs A had diarrhoea. RN C contacted a general practitioner (GP) by fax, requesting a prescription for loperamide.[2] He did not provide the GP with any other information regarding Mrs A's symptoms, and did not consider that further intervention was required. RN C put an isolation notice on Mrs A's door as an infection control precaution, but did not send a specimen for testing.

5. RN C did not work on Day 7 or Day 8. He was on call but he was not contacted by any of the rest home staff on those two days. Mrs A vomited on Day 7, and it was noted that she was barely eating. Various caregivers noted Mrs A's deterioration during this time.

6. On Day 9, a caregiver who had been off duty for 10 days returned and noticed Mrs A's weight loss. The caregiver did not contact RN C, who was on call. The caregiver informed HDC that Mrs A consumed some replacement energy drink, but this was not documented. RN C returned to duty that afternoon. During handover, the caregiver told RN C that she felt that Mrs A needed to see a doctor. RN C assessed that Mrs A was in danger of dehydration, and encouraged fluids.

7. At 10pm Mrs A had an episode of diarrhoea. She was given loperamide, and the night caregiver staff were instructed by RN C to encourage fluids and monitor Mrs A. RN C did not call a doctor or an ambulance. No vital signs or observations were recorded, and no food or fluid intake chart was initiated. Medical attention was considered but not sought. RN C said that emergency admission/assessment did not appear to be necessary. He planned to call a GP first thing the next day, a Monday, Day 10.

[1] Relevant dates are referred to as Day 1-Day 10 to protect privacy.
[2] Anti-diarrhoeal medication.

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8. Between Day 1 and Day 9, RN C made no arrangements for any medical assessment of Mrs A. No blood pressure readings or respiratory rates were taken.

9. On Day 10, RN C checked Mrs A and made an appointment for the GP to visit at 11am. After breakfast, Mrs A was very unwell, and RN C called an ambulance. Mrs A was transferred and admitted to hospital before the scheduled GP visit. RN C notified Mrs A's granddaughter, Ms B, of Mrs A's transfer to hospital, but prior to this Ms B had been unaware of Mrs A's deteriorating condition.

10. Hospital records document that Mrs A presented with a four- to five-day history of diarrhoea. Mrs A described feeling a shortness of breath over the previous two weeks, and had a cough. Bloods and investigations were undertaken. Treating staff formed the clinical impression that Mrs A had a diarrhoeal illness with acute renal impairment, heart failure, and a respiratory tract infection. Three days later, Mrs A passed away in hospital. Her death certificate noted the cause of death as congestive heart failure, dehydration, diarrhoea, and coronary atherosclerosis.[3]

Findings

11. RN C's assessment, monitoring and evaluation of Mrs A's vital signs and condition, and his management of her symptoms, were inadequate. Accordingly, he did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.[4]

12. RN C's documentation did not comply with professional nursing standards and, accordingly, he breached Right 4(2) of the Code.[5] RN C did not provide information to other staff about Mrs A's changing clinical circumstances, and this contributed to the lack of continuity and quality in Mrs A's care. Accordingly, RN C breached Right 4(5) of the Code.[6]

13. Adverse comment was made regarding Ms E, an experienced caregiver who recognised Mrs A's deterioration on Day 9 but failed to seek assistance.

14. The decision to assign to an inexperienced graduate nurse, without clinical supervision, the responsibility for the direction and delegation of care for rest home residents was inappropriate, and placed both the residents and the nurse at risk. Beta Pacifica Corporation Limited did not take sufficient steps to ensure that appropriate systems were in place to provide services to Mrs A with reasonable care and skill. Therefore, it breached Right 4(1) of the Code. By failing to ensure that staff were complying with policies and procedures, it failed to comply with the Health and Disability Sector Standards and breached Right 4(2) of the Code.

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[3] Hardening and narrowing of the arteries.

[4] Right 4(1) of the Code provides that "[e]very consumer has the right to have services provided with reasonable care and skill".

[5] Right 4(2) of the Code provides that "[e]very consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards".

[6] Right 4(5) of the Code provides that "[e]very consumer has the right to co-operation among providers to ensure quality and continuity of services".

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Complaint and investigation

15. Ms B complained to HDC about the care provided to her grandmother, Mrs A. The following issues were identified for investigation:

- *Whether the care provided to Mrs A by Beta Pacifica Corporation Ltd in 2011 was appropriate.*
- *Whether the care provided to Mrs A by RN C in 2011 was appropriate.*

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

17. The parties involved in the investigation were:

Ms B	Complainant, Mrs A's granddaughter
Beta Pacifica Corporation Limited	Provider
RN C	Registered nurse (RN)
RN D	Clinical services manager
Ms E	Caregiver
Dr F	General practitioner (GP)
Ms G	Facility manager
The District Health Board	Funder

Also mentioned in this report

Mr H	General manager

Information was also obtained from:

Ministry of Health
ACC
Nursing Council of New Zealand

18. Independent advice was obtained from an expert in gerontological nursing, Ms Tanya Bish (Appendix A).

Information gathered during investigation

Mrs A

Background

19. On 30 July 2009 Mrs A, aged 81 years, was admitted to a rest home which was owned by Beta Pacifica Corporation Limited (Beta Pacifica) (the rest home has since closed). Mrs A had been assessed by the Needs Assessment Co-ordination Service (NASC) for the District Health Board as requiring rest home level care.

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20. At that time, Mrs A's medical conditions included chronic obstructive pulmonary disease (COPD), ischaemic heart disease, hypothyroidism, and osteoarthritis in her left hip. She was unstable on her feet, and used a walker. Mrs A was taking multiple medications.[7]

Care planning

21. On 10 September 2010, a detailed lifestyle care plan was documented by the Clinical Services Manager at the rest home, RN D, a registered nurse.[8] As part of the plan, vital signs and weight[9] were required to be recorded monthly.

22. The care plan stated:

> "Document any changes observed in [Mrs A's] progress notes and inform the RN with any concerns; [Mrs A's] health status to be reviewed by her GP at least 3/12; in cooperation with [Mrs A], ensure that her family are kept well informed about any changes in health status."

23. Discussions had also taken place with Mrs A regarding her wishes, advance care planning, and care at the end of life. Mrs A made her own decisions.

24. The care plan was evaluated and updated approximately six months later and it notes that Mrs A said she wanted to be treated actively in the event of acute illness. Mrs A also wished to go to hospital for end-of-life care.

25. Some aspects of Mrs A's care plan were evaluated further, but a complete care plan evaluation was not completed as required.

Medical review arrangements — the rest home

26. Mrs A was to be reviewed on a three-monthly basis from September 2010 onwards, in accordance with her care plan and as per the exception in Age Related Residential Care Services Agreements.[10] Medical care was provided primarily by practitioners from a local medical centre.

27. Beta Pacifica told HDC that it did not have contracts for GPs who worked at the rest home,[11] and the facility did not have a "House Doctor". A number of GPs provided services to the residents at the facility, as was standard for its other facilities.

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[7] These were: frusemide, allopurinol, candesartan, celecoxib, amitryptiline, paracetamol, metoprolol, omeprazole, cholecalciferol, citalopram, levothyroxine, cetirizine, and Duolin inhaler.

[8] RN D retired from nursing in 2013 and is no longer registered.

[9] Mrs A's weight had been recorded on 10 August 2010 as 57kg. A year later, her blood pressure was recorded as 106/54mmHg (no baseline available), and her temperature as 36.5°C.

[10] Section D16.5, e. i. 1. states: "… After the initial examination, the Subsidised Resident must be examined not less than once a month and as clinically indicated (as assessed by a Registered Nurse) ***except*** [original emphasis] where the Subsidised Resident's medical condition is stable as assessed by the General Practitioner, in which case the Subsidised Resident may be examined by a General Practitioner less frequently than monthly, but at least every three months. This exception must be noted and signed in the Subsidised Resident's medical records by the General Practitioner."

[11] The Age Related Residential Care Services Agreement does not require this.

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28. Mrs A's GP, Dr F, completed a "Monthly Doctor's Visit Exemption" form, which states: "In my opinion [Mrs A] is regarded as sufficiently medically stable to qualify for a routine 3-monthly doctor's visit." Dr F told HDC that there was an expectation that the rest home would report to the GP any change in a patient's medical condition of concern or significance, and request advice or review.

RN C

Registered nurse job description and employment agreement

29. From mid 2011, RN C began employment as a registered nurse at the rest home and at another facility operated by Beta Pacifica.[12] At that time a Clinical Services Manager (RN D) and a Facility Manager (Ms G) were employed at the rest home. Ms G was experienced in the aged care sector, but did not have clinical qualifications.

30. RN C's appointment as a registered nurse at the rest home and the second facility was his first position after graduating. He had achieved his nursing registration in December 2010.[13]

31. RN C's job description for the position of registered nurse, signed and dated by him on 28 April 2011, states that one of the two primary objectives was: "To ensure that safe individualised quality care is provided to residents, and assist them to achieve their optimum level of wellness." RN C reported to the Facility Manager, Ms G,[14] but was supervised by the Clinical Services Manager, RN D.

32. RN C's key responsibilities and performance standards included the following:

- Following policies and procedures of the facility in all matters.
- Providing competent professional clinical practice as a registered nurse within relevant legislation.
- Seeking guidance from senior staff when appropriate.
- Ensuring quality resident care was carried out based on set standards and the policies and procedures of the facility including: making comprehensive assessments of residents and monitoring care; ensuring residents' care plans were evaluated, reviewed and amended when clinically indicated by a change in the resident's condition; safely administering medications and conducting treatment and care; taking appropriate initiative in resident management.
- Ensuring documentation met legal requirements, including progress notes being completed daily by a registered nurse or at least viewed daily.
- Maintaining effective communication with all residents/families/visitors.

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[12] This facility provides rest home level care and is situated a few kilometres from Mrs A's rest home.

[13] New nursing graduate programmes recommend that a qualified registered nurse preceptor be available to a new graduate during his or her first year of practice. RN C said that he was not able to access the Nurse Entry to Practice Programme via the DHB in 2011 as very few students are in a position to do so, and his employer was not obliged to provide a preceptor. The DHB advised HDC that 21 nursing graduates used the programme that year — one in the area of aged residential care.

[14] Ms G advised that she had worked in aged care overseas and in New Zealand for many years, and as a facility manager since 1999.

HDC

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- A reporting requirement to inform "the Clinical Manager of any significant issues".
- Maintaining effective working relationships with medical practitioners and other health professionals, including referring residents when appropriate.
- Maintaining knowledge on infection control matters.
- Undertaking on-call duties as required.

33. RN C told HDC that his generic job description did not include issues that he recalled had been discussed at interview, such as his working under the supervision of the Clinical Services Manager.

Registered nurse supervision, orientation and training

34. RN C told HDC that he was employed to work under the supervision of the Clinical Services Manager, RN D, a registered nurse, at both the rest home and the second facility.

35. RN C said that he was given an orientation programme of two weeks, working with RN D, and that over the next three months he was always under supervision, and "she was constantly teaching and training [me]". RN D concurred that RN C worked closely with her for that period. She said that he was progressing well under supervision. RN D told HDC that while working under her direction, clinical priorities were set by her while RN C learned to establish weekly and monthly routines to follow, to maintain clinical compliance.

36. RN C said that he was required to familiarise himself with all policy and procedure documents, resident files, medications, routines, registered nurse responsibilities, and the residents themselves. He said that he rotated between the two homes.

37. Limited staff training documents were provided to HDC by Beta Pacifica. These showed that RN C attended training on policies and procedures, and on the Code of Health and Disability Services Consumers' Rights.

38. Other documents provided by Beta Pacifica list RN C as being enrolled to attend cultural awareness and civil defence and emergency readiness training, communication, and open disclosure. However, his attendance is unconfirmed as the records are all undated and unsigned by RN C.

39. RN C told HDC that he attended in-service training on care planning but no evidence of this was provided.

Staffing at the rest home in 2011

40. The policy document entitled "Direction and Delegation" states that Beta Pacifica:

> "will maintain a well defined management structure, both at facility level and organisational level, to ensure staff are supported and given direction in their role".

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41. The document also states that the company has a "well defined recruitment and screening programme that ensures that staff have the appropriate skill and abilities for their position" and that performance appraisals are used to assess whether staff work within their scope of practice and job descriptions.

Clinical Services Manager

42. RN D advised that in early 2011, the Clinical Services Manager at the second facility left that position. RN D was then responsible for both homes for a period. She advised HDC that recruitment of a replacement Clinical Services Manager for the second facility was very difficult.

43. In mid 2011, RN D ceased her employment as Clinical Services Manager at the rest home. Mr H, General Manager of Beta Pacifica, told HDC that the company made no arrangements to replace her.

44. It was arranged that RN C work full time at the rest home, where he would be the sole registered nurse, and a new registered nurse was employed to work at the second facility. Neither site had a Clinical Services Manager and, therefore, the registered nurse at each site was responsible for the clinical oversight of all residents. At this time, there were 21 residents at the rest home. RN C's contract stated that he was not required to work more that 10 hours per day or 80 hours a fortnight. On-call responsibilities were separated into clinical and non-clinical issues. On-call clinical cover was provided by RN C or the registered nurse from the second facility, and non-clinical cover was provided by the Facility Manager, Ms G.

45. RN C said that while another registered nurse was being recruited for the second facility, there was a period of about seven weeks where he covered registered nurse duties for both rest homes (totalling about 45 residents), and he was the only person on call.[15] He said that during this period it was very difficult for him, as he had to make decisions unaided, and there was no clinical leader to direct him.

46. RN C told HDC that when RN D resigned he had been employed for three months. He said that he told Beta Pacifica management of his concerns about the lack of a clinical services manager and clinical supervision. He was concerned that Ms G did not have a clinical background. RN D also told HDC that she recalled that RN C had voiced concerns about his clinical supervision.

47. In response to HDC's query about arrangements made to supervise the progress of RN C after the Clinical Services Manager had resigned, Beta Pacifica told HDC that the rest home had an "informal arrangement with another facility [the third facility] where clinical support and advice could be accessed if requested".

48. RN C told HDC that to the best of his knowledge there were no arrangements in place with the third facility at that time. He had never been to the third facility or been told that he could access clinical support and advice from its staff. He recalled that after

[15] I note that a new registered nurse began employment at the second facility about four weeks later.

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Mrs A's family complained, two managers from the third facility visited the rest home, advising that they were available to take calls and offer advice.

Appraisal

49. RN C had a three-month appraisal. This was performed by Ms G two days after RN D ceased her employment.

50. RN C's feedback to his employer on the appraisal documentation was largely positive, indicating that he considered his orientation to have been very good, staff were helpful, he was aware of policies and procedures, and he enjoyed the work. He did not document any concerns, but made one comment that he hoped in the near future that "2 can work following the roster, specifically divide the work hours".

51. In the "Summary of Staff Appraisal", the appraiser comments include:

> "The work hours have been a real challenge. [RN C] had a lot of pressure from the previous clinical manager. These will now change. New RN sharing on call will start on [Day 3]. Each RN will be required to work 40hrs a wk and 1 on call weekend (every other)."

52. The appraisal includes further comments from RN C and Ms G that RN C had fitted in well, acknowledged that he had had a hard start due to staff changes, he was comfortable working at the facility, he hoped to work more on the floor, he was hard working, and he looked to improve his communication skills and ask more questions. RN C stated that he wished to improve his skills in care planning, time management, assessment, and emergency.

Mrs A's clinical care at the rest home — Day 1 to Day 10

53. On Day 1, Mrs A was coughing intermittently, and her nose was running. This was described in the progress notes the following day by caregiver Ms E, as a "very heavy cold". Mrs A had almost lost her voice. Fluids were encouraged and she was given Gees Linctus[16] 5ml.

54. The rest home's "Policy on Unwell or Injured Residents"[17] states that if a resident is found to be ill or injured, then the staff member will protect the resident's safety, call other staff for help, stay with the resident or call the registered nurse in charge or on call, reassure the resident until the registered nurse arrives, administer first aid as able, and then provide details of the resident's illness to the registered nurse on arrival. Ms E did not bring Mrs A's condition to RN C's attention on Day 1.

55. Ms B told HDC that she had spoken to her grandmother, Mrs A, on the weekend of Day 2, and that Mrs A told her that her cough had been ongoing for a number of weeks.

[16] An over-the-counter expectorant cough mixture.
[17] Date issued July 2010.

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56. On Day 3 2011, RN C did not work at the rest home, as he was assisting the new registered nurse who had started at the second facility.

Day 4

57. On Day 4, RN C, as evidenced by his review in the progress notes, became aware of Mrs A's change in health status. That day, RN C assessed Mrs A and recorded:

> "Not feeling well this morning. Lost her voice. T 37°C, didn't want her breakfast, had a cup of tea. Been up and sitting in the chair, lunch offered in her room. Had her lunch, appears better. [Bowels open.]"

58. Part 2 of the "Policy on Unwell or Injured Residents" refers to the "Procedure for Registered Nurse Assessment". It outlines the requirement for a registered nurse to establish the status of the resident and initiate first aid/treatment, establish details of the illness, instruct caregivers on interim care, gather documentation, assess further (from a checklist including blood pressure) according to priority, and establish whether a doctor's advice is needed.

59. In addition, the rest home's policy document "Guidelines on Writing Care Plans (Individual Lifestyle Plans)"[18] states that the governing standard is "All of the facility's care plans (Lifestyle plans) are to be completed according to Ministry of Health and District Health Board contract requirements and current accepted good practice". Point 10 of this document outlines that "[s]pecific short-term care plans are kept (with long term plans) for the duration of a specific problem and once resolved are filed in old notes".

60. No short-term care plan was put in place to inform the caregivers of any monitoring or interventions required in response to Mrs A's condition at that time.

Day 5

61. On the morning shift of Day 5, caregiving staff noted in Mrs A's progress notes: "Staff member assisted with her shower today. She is feeling better. Came to dining room for lunch." The afternoon shift recorded: "Remains in bed still unwell." It was noted that Mrs A slept well between checks that night.

Day 6

62. On the morning shift of Day 6, RN C recorded:

> "RN checked [Mrs A] this morning she complain she lost her voice. OB taken T=36.2, pulse 66, Resp 98%. No cough. No signs of chest of infection. No sore throat. She said she just feeling unwell, very tired, lemon drinks offered, she had her morning tea, but doesn't want her dinner. She just want stay in bed for rest."

63. Guideline 3 of the "Policy on Visits by Medical Practitioners" states: "The Facility Manager/Nurse Manager or Registered Nurse contacts the GP and requests a visit

[18] Issued July 2010.

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whenever there is a significant change in the Resident's condition or inappropriate response to treatment."

64. RN C told HDC that after assessing Mrs A on Day 6, he did not consider that further intervention was required, other than his fax contact with the GP (detailed below). RN C did not put in place a short-term care plan at this time to inform the caregivers of any monitoring or interventions required.

65. At 1.30pm, caregiver staff noted: "[Mrs A] still has diarrhoea. I have just changed her nightie etc again. I have put a pull up on her with her permission. Gone back to bed."

66. RN C told HDC that until he saw that entry he was not aware that Mrs A had diarrhoea. He had not been advised by other staff, and it had not been documented previously. That afternoon, RN C documented in the progress notes:

> "RN contacted GP to charted some Nodia (lopermide) tabs for her losing bowels. Staff please keep her in her room, do not let her walking around."

67. RN C said that Mrs A had no other apparent symptoms. He contacted GP Dr F by fax requesting a prescription. He stated in the fax:

> "[Mrs A] have some loosing bowel today. Can you please chart some Nodia (loperamide) tabs for her PRN. Please send the script to [the] pharmacy. Thank you very much."

68. Part 3 of the "Policy on Unwell or Injured Residents" refers to the "Procedure for Contacting Duty Doctor" and requires that "all relevant detail is on hand before contact is made" including documentation, "history of current illness or injury" and "recordings from R/N assessment". It is required that the registered nurse record the advice provided.

69. There is no information recorded in the progress notes to indicate that Dr F was given any information by RN C other than that Mrs A had diarrhoea. Dr F told HDC that the request for loperamide by fax was complied with. He said that a history of one day's diarrhoea would not have raised a red flag for him, and that loperamide was often on rest home standing order charts. In response to the provisional opinion, RN C stated that it is unreasonable to expect him, a new graduate, to see red flags.

70. Part 4 of the "Policy on Unwell or Injured Residents" describes a "Procedure for Recording Duty Doctor Verbal Instructions", which requires that the registered nurse repeat back the verbal instructions to establish accuracy. The "Policy on Visits by Medical Practitioners"[19] states that "a copy of the current medication chart will be faxed through to the GP who will make any changes and sign, date in the usual way. This photocopy will be attached to the Medication Chart and signed on the original Medication Chart at the next visit."

[19] Issued July 2010. Guidelines section. Point 5.

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71. There is no photocopy of a signed order for loperamide with the medication charts on file. RN C did not document, as required, in the PRN medicines part of the medication chart that the script he requested had been a faxed order.

72. RN C placed an isolation notice on Mrs A's door as an infection control precaution. He said that he did so as he was the only registered nurse, and he was responsible for the other residents as well. He said that he was not familiar with any protocol to send a specimen for testing, so he did not undertake this. There were no documented instructions to staff regarding potential precautionary measures.

73. Night staff recorded that Mrs A had used the call bell at 2am, and went to the toilet, having a loose bowel motion.

Friday Day 7

74. On Day 7, RN C was not on duty, although he was on call. The following was recorded in the progress notes by various caregivers on duty:

Date	Time/duty	Comments[20] (*entries made by caregivers unless stated otherwise*)
[Day 7]	AM	Remains in bed vomiting this morning new medication arrived loperamide, tabs given at 1125am not eating, drinking only water has had all medication.
	PM	Continues to remain in bed. Still has loose bowels. Tabs loperamide given at 1830, Barely eating, not drinking.
	Night	Up to Toilet @0230. Still not feeling well. Said she thinks she should be in hospital. Made her a lemon and honey drink.

75. A "Use of On-call Nurse" policy was in place for after-hours contacts. This stated that "the Facility Manager/Nurse Manager or a designated senior Registered Nurse should be contacted for all clinical issues. The staff will be notified of who is on call."

76. Although RN C was on call, he was not contacted regarding Mrs A's condition on Day 7.

77. In her complaint to HDC, Ms B recounted that her grandmother stated to her around this time that she had asked to be seen by a doctor, and that staff should not have let her get this sick.

[20] For accuracy and for the purposes of this report, the entries in the progress notes are verbatim, including grammatical and spelling errors.

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Saturday Day 8

78. On Saturday, the following was recorded in the progress notes, again by caregivers. RN C was not on duty on this day, but he was on call and was not contacted about Mrs A's condition that day:

Date	Time/duty	Comments (*entries made by caregivers unless stated otherwise*)
[Day 8]	AM	Remains in bed today, not eating much only drinking.
	PM	Still remains in bed, is not eating hardly anything and is also not drinking very much. Mrs A seems to think the hospital is the answer to her health. Explained that the diarrhoea is probably a bug and there's nothing much that can be done it will take its course and she has lost her voice due to cough? Chest infection. All in all she is feeling very miserable ? needs to see a doctor.

Sunday Day 9

79. On Sunday, the following was recorded in the progress notes:

Date	Time/duty	Comments (*entries made by caregivers unless stated otherwise*)
[Day 9]	AM	[Mrs A] is very unwell appears to have lost weight. Resident can't walk without staff assistance. She needs a GP this has been ongoing unwell for a week now ate a cracker for m-tea and had a mini amount of dessert. Encouraged to drink cold water this duty. [Ms E]
	PM	Very ill in bed not eating her dinner had small amount of soup and tea. RN encouraged her to drink some water to prevent dehydration, she had about 200ml water, afterwards she vomited but keep encourage her to drink water. Night staff please keep eye on her, check her every hour. [RN C]
	PM additional	Add; [Mrs A] had a badly losing bowels, pad and linen changed. Isolation applied. Staff please use alcohol wipes to clean the equipment after use. Please use mask foot and cloves when contact and doing patient care lopermide given at 22:00. [RN C]
	Night	Slept well during all checks, heard calling on some times

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80. On Day 9, caregiver Ms E[21] returned from ten days' leave. She told HDC that she was shocked to see the deterioration in Mrs A's condition, and purchased replacement energy drink for her. She recalled Mrs A drinking about 850ml over her shift without vomiting or having diarrhoea.

81. The progress notes from this shift are the first mention of possible weight loss. The actual weight was not recorded. Mrs A's weight was not being recorded monthly as per her long-term care plan. The rest home policy "Weight loss — Assessment and Management"[22] outlines that weight loss will be followed up when it is unexplained or involuntary. The resident's GP must be informed and a "food and fluid record is commenced and maintained".

82. Ms E advised that she handed over to RN C when he arrived in the afternoon, and told him that she felt Mrs A needed to see a doctor. RN C worked from approximately 1pm to 11pm, covering a caregiver's shift. He told HDC that there was nothing to suggest to him that there was a problem until he spoke with Ms E.

83. RN C said that he assessed that Mrs A was "probably in danger of dehydration", even though she did not have any vomiting or diarrhoea that morning. He encouraged fluids. RN C said that Mrs A had about 1500ml of Mizone replacement energy drink in 24 hours. The use of the energy drink was not recorded in the notes.

84. At 10pm Mrs A had an episode of diarrhoea. She was given loperamide, and the night caregiving staff were instructed to give fluids and monitor Mrs A. RN C did not call a doctor or an ambulance. No vital signs or observations were recorded. Medical attention was considered but not sought. No food or fluid intake chart was initiated.

85. RN C advised that he could not get a doctor to visit on the weekend. He told HDC:

> "As far as I am aware, the rest home did not have a policy about contacting a GP after hours. The only option I had after hours or on the weekend was to call an ambulance and transfer the patient to [hospital]. If a patient was mobile and well enough, we could take them to the emergency clinic during their opening hours. But there was no 24 hour service (apart from the hospital) in [the area]. In each case, it comes down to a judgement call by the RN. I feel this is where my lack of experience and supervision was not acknowledged by management or the company."

86. RN C said that he could have sent Mrs A to the hospital emergency department on Sunday, as this was his only option, but he considered that emergency admission/assessment did not appear to be necessary. He was going to call the GP first thing the next day, a Monday.

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[21] Now retired.
[22] Issued July 2010.

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87. The rest home's "Policy on visits by Medical Practitioners"[23] includes guideline 6, that "each on call emergency medical services [sic] must be available 24 hours a day". There was no specific rest home policy document detailing a process for staff to follow to access after-hours medical care or emergency care if required.

88. RN D, the Clinical Services Manager, told HDC that in the area, access to after-hours medical services from a doctor was limited. There were two after-hours medical clinics in the area. Those clinics operated from approximately 8am to 8–8.30pm. The other option was to call an ambulance. RN D recalled that in some limited circumstances a GP might visit a resident between about 5–7pm, but only if this was arranged beforehand.[24]

Monday Day 10

89. RN C checked Mrs A in the morning and said that he made an appointment for the GP to visit at 11am. Dr F told HDC that he recalls his practice receiving a telephone request to visit the rest home. His recollection is that Mrs A was dyspnoeic.[25] There is no record in Mrs A's rest home progress notes of Dr F being telephoned. After Mrs A had been given breakfast (of fruit and further energy drink), Ms E reported to RN C that Mrs A was now very unwell. RN C called an ambulance.

90. RN C noted in the morning shift progress notes: "Sent [Mrs A] to [the] DHB this am due to her terrible flu family has informed. RN will following any progression."

91. RN C notified Ms B of her grandmother's condition and pending transfer to hospital. In her complaint to HDC, Ms B recalled that RN C telephoned her to inform her that her grandmother was very sick, and that an ambulance was on its way. Ms B told HDC that RN C had said to her that Mrs A was short of breath and had diarrhoea. Ms B told HDC that prior to this contact she had been unaware of her grandmother's deteriorating condition, other than what her grandmother had told her.

92. Mrs A was transferred by ambulance and admitted to hospital.

93. Dr F said that he arrived at the rest home around lunchtime to find that Mrs A had already been sent to hospital. Dr F had not been informed of this.

94. Between Day 1 and Day 6, RN C did not put in place a short-term care plan to guide caregiving staff on their care of Mrs A, and no arrangement was made for a medical assessment of Mrs A. No blood pressure measurements or respiratory rates are recorded in the progress notes.

Hospital admission

95. Ms B told HDC that admitting hospital staff advised her that Mrs A was dehydrated.

96. Hospital records document that Mrs A presented on Day 10 with a four- to five-day history of diarrhoea. Mrs A described feeling a shortness of breath over the previous

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[23] Issued July 2010.
[24] In some circumstances this could incur a charge.
[25] Short of breath or having difficulty breathing.

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two weeks, and she had a cough but no chest pain. On examination, Mrs A was tachycardic and hypotensive. Bloods and investigations were undertaken. Treating staff formed the clinical impression that Mrs A had a diarrhoeal illness with acute renal impairment, heart failure, and a respiratory tract infection. Mrs A was admitted to the ward and given intravenous fluids and antibiotics. A decision was made that Mrs A would not receive treatment escalation. She later received morphine and hyoscine.[26]

97. Mrs A passed away in hospital. Her death certificate noted the cause of death as congestive heart failure (six days' duration), dehydration (eight days' duration), diarrhoea (nine days' duration), and coronary atherosclerosis.

Further information

98. RN C said that as an inexperienced registered nurse, he was placed in a position with responsibilities beyond what he was employed to do. He felt that he was put under impossible pressure to maintain clinical safety in both homes, which caused him stress. He told HDC that he felt powerless and intimidated, and worried about losing his job. He said that he was consistently working over and above the call of duty, most often working 11-hour days, which was in effect the job of two registered nurses. He said that he was always on call, day and night. At night, there was only one caregiver on duty in each home, and he was the caregiver's only support. In response to the provisional report, RN C's legal representative stated:

> "[RN C's] very heavy workload meant he simply did not have enough time to regularly review and update care plans and the like. Any additional time he spent on paperwork would have been at the expense of 'time on the floor' attending to residents. [RN C] regularly worked beyond the hours provided for in his employment agreement … in an attempt to keep up with his very heavy workload."

99. Ms E told HDC that she considered that, at the time, RN C was doing the work of two registered nurses between the two facilities, and that he was also helping shower clients one morning per week and performing a caregiver shift. Ms E said that she could see that RN C was very stressed and concerned about the responsibility he was trying to manage.

100. RN C said that the most important thing he has learnt is that he would never leave an inexperienced staff member to make important decisions such as he had to make alone and unsupported. He will now always ensure that he has senior and suitably qualified staff to work with him and to discuss any decisions he has to make. He has learnt the "true and real value of experience when making clinical assessments". He has endeavoured to observe the senior nurses with whom he works, to learn as much as possible.

[26] To relieve stomach pain and bowel cramps.

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Subsequent events

101. Ms B complained to the rest home, the Ministry of Health (HealthCERT), and the DHB about the services provided to her grandmother.

102. The DHB contacted the rest home management. Beta Pacifica arranged an investigation into Ms B's complaint about the rest home.

103. The DHB's Director of Nursing also reviewed the care the rest home provided to Mrs A, and made a number of corrective recommendations, which included providing RN C with specific clinical supervision at an alternative residential care facility. Corrective actions identified by the DHB included a requirement for the rest home to put in place appropriate clinical oversight arrangements. Rest home management were tasked with providing an "escalation path" and further training for the rest home staff.

104. RN C was seconded to another facility (a third facility) to work under the supervision of the Facility Manager and the Clinical Services Managers, both of whom were experienced senior nurses. He attended in-service training on care planning, and attended a NZ Aged Care Association registered nurse study day, which covered topics such as wound care, laboratory results, medication, and speech therapy.

105. The DHB met with Beta Pacifica General Manager Mr H to discuss the DHB review report. Mr H met with Ms B and her father to discuss their concerns.

106. The DHB wrote to Ms B advising that, following the DHB review, a series of recommendations had been made to Beta Pacifica, and corrective actions were being carried out. The DHB advised Ms B that the DHB and Ministry of Health would continue to monitor the rest home closely, and that an unannounced audit of the facility was planned. This was carried out in January 2012.

107. Mr H apologised to Ms B in writing, and attached a copy of the investigation report. Between February and March 2012, RN C was placed in a rest home for further supervision and mentoring. On 3 April 2012, Mr H met with Ms B again to discuss her comments on the investigation report.

108. RN C told HDC that in the period March 2012 to June 2013, he undertook further education and training in: restraint versus enablers; chemical safety; pressure injury; catheterisation; manual handling; continence; syringe driver competency; code of conduct; infection control; and workplace first aid.

109. In May 2012, a treatment injury claim was lodged with ACC in relation to Mrs A's illness. The claim was accepted in early 2013. ACC advisors were of the view that there were deficiencies in the care provided to Mrs A at the rest home.

110. The rest home later closed, and all residents were relocated to other facilities. RN C is now employed at a facility in another region.

111. In response to the provisional report, RN C's legal representative advised HDC:

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- It is accepted that there are some fundamental standards that all registered nurses must meet, regardless of their level of experience, but a nurse faced with insurmountable pressure should not face harsh criticism if that nurse has acted reasonably in the circumstances and has taken steps to ensure that events are not repeated in the future.

- RN C has gained considerable experience since these events. He now works under supervision and with other nurses in a more collegial environment. Mrs A's death and the subsequent investigation and complaint have caused him to reflect carefully on his practice and identify areas for improvement and further training. The experience of the complaint itself served a rehabilitative function.

- RN C's latest performance appraisal was very positive, including in the areas of assessment, care planning, reporting, documentation, and liaising with GPs. RN C wishes to continue advancing in the nursing profession.

112. In response to the provisional opinion, Ms E advised HDC that she left her employment with the rest home and retired in late 2011.

Relevant standards

113. The Nursing Council of New Zealand *Competencies for Registered Nurses*[27] include:

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

[27] Nursing Council of New Zealand, *Competencies for Registered Nurses*, Wellington: NCNZ (2007, reprinted 2012).

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…

Competency 4.1
Collaborates and participates with colleagues and members of the heath care team to facilitate and co-ordinate care.”

114. The *NZS Health and Disability Services (General) Standards* (Standards New Zealand, 2008) include:

NZS 8134.1.1:2008 — Standard 1.8, which states that “consumers receive services of an appropriate standard”.

NZS 8134.1.1:2008 — Standard 2.2, which states: “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.”

NZS 8134.1.3:2008 — Standard 3.6, which states that “consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes”.

NZS 8134.1.3:2008 — Standard 3.4, which states that “consumers’ needs, support requirements, and preferences are gathered and recorded in a timely manner”. Criteria 3.4.2 for this standard states that “the needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning”.

115. Relevant sections of the *Age Related Residential Care Service Agreement* include:

Section D16.5, e. i. 1:

“… After the initial examination, the Subsidised Resident must be examined not less than once a month and as clinically indicated (as assessed by a Registered Nurse) ***except*** [original emphasis] where the Subsidised Resident’s medical condition is stable as assessed by the General Practitioner, in which case the Subsidised Resident may be examined by a General Practitioner less frequently than monthly, but at least every three months. This exception must be noted and signed in the Subsidised Resident’s medical records by the General Practitioner.”

Section D17.3 Rest Homes:

“b. Despite clause D17.3(a), where (having regard to the layout of the Facility, the health and personal care needs of Residents and the ease with which the Residents can be supervised) the Registered Nurse or Manager at any time considers that additional staff are required to meet the needs of all Subsidised Residents, you shall ensure that those extra staff are On Duty for the period of time that the Registered Nurse or Manager recommends.”

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Responses to provisional opinion

116. Responses to the provisional opinion were received from all parties, and have been incorporated into the "information gathered" section where relevant. In addition, the following responses were received.

117. Beta Pacifica Corporation Limited stated that it accepted the Deputy Commissioner's findings, including Beta Pacifica Corporation Limited being named in the final report. General Manager Mr H added that "one instance of poor care is one too many and we are disappointed this occurred. Since the incident we have made a number of changes to ensure this incident does not occur again."

118. RN C's lawyer stated that RN C "sincerely regrets the loss which [Mrs A's] family has suffered. He acknowledges that there were shortcomings in [Mrs A's] care. He also acknowledged that a more senior and experienced nurse might have handled [Mrs A's] care differently. But [RN C] clearly lacked experience and time …"

119. RN C submitted that the shortcomings in Mrs A's care stemmed from organisational deficiencies; that primary responsibility should lie with his employer; that there were failings on the part of other individuals; and that the proposed findings of the Deputy Commissioner were unduly severe.

120. The complaint has caused RN C considerable stress and anxiety, although he acknowledges that this may pale into insignificance when compared with the loss that Mrs A's family has suffered. RN C sincerely regrets the family's distress and loss, and is happy to apologise.

121. RN C advised that he can provide HDC with full details of his supervision, mentoring activities and educational development.

Opinion: Preliminary comments

Introduction

122. Mrs A was an elderly rest home resident with complex co-morbidities. It is evident from the information gathered that in the period from Day 1 to Day 10 a series of serious deficiencies in her care occurred. In my view, Mrs A did not receive the standard of care she was entitled to in light of her symptoms and her subsequent deteriorating condition. Having reviewed all responses to the provisional opinion, I remain of the view that there were multiple departures from professional nursing standards and established policy, in tandem with overarching organisational failures.

123. Mrs A's care was characterised by deficiencies in relation to: her assessment, monitoring and evaluation; care planning; documentation; communication among staff; compliance with policies and procedure; staffing and skill mix; and the clinical supervision and oversight of staff — particularly that of RN C, an inexperienced graduate nurse.

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Opinion: RN C

Assessment and monitoring — Breach

124. On Day 4, when RN C noted that Mrs A had a cough and was losing her voice, he was responsible for assessing the change in her condition and developing any care interventions required in the context of her known medical problems. However, his initial assessment of Mrs A was minimal at that time. RN C documented having taken Mrs A's temperature, but did not put in place a short-term care plan to inform the caregivers of any monitoring and intervention Mrs A required in response to her condition at that time.

125. Mrs A continued to feel unwell. RN C said that on Day 6, Mrs A had no apparent symptoms apart from diarrhoea. RN C did not put in place a short-term care plan at this time. RN C contacted GP Dr F, via fax, to request a prescription for an anti-diarrhoeal medication, but did not provide the GP with any other information about Mrs A's condition, as he did not consider that any further intervention was required. This was contrary to Beta Pacifica's policy, which set out the information required before contact was made with a duty doctor.

126. RN C felt that Mrs A needed to be placed in isolation in her room as an infection control precaution, but no specimen was taken as he was not aware of the protocol for this. My expert nursing advisor, Ms Tanya Bish, advised:

> "[T]his degree of caution was appropriate given the cause of the diarrhoea had not been confirmed and therefore the potential risk to other residents. It would have been advisable to collect a faecal specimen for laboratory analysis to assist in the identification of the cause of the diarrhoea."

127. Mrs A's condition continued to deteriorate on Day 7 and Day 8. RN C was not on duty on those days and, although he was on call, he was not contacted about her condition.

128. On Day 9, RN C returned to work at the rest home. It is clear from the notes RN C made that day that, at this time, he was aware that Mrs A was still unwell, had vomited after taking fluids, and still had diarrhoea. Despite this, there is no evidence that Mrs A's vital signs were taken regularly, or that a short-term care plan was put in place. There is little documented evidence that RN C was actively monitoring Mrs A's progress. While RN C and other staff did encourage food and fluid intake, particularly on Day 6, RN C did not monitor the fluid intake/output or implement a fluid chart, or document the use of the energy drink used. This should have been monitored and documented in light of Mrs A's vomiting and diarrhoea. No blood pressure or respiratory rates were recorded between Day 1 and Day 10. Mrs A's vital signs were taken only sporadically. Ms Bish advised that blood pressure "is considered a vital sign and would usually be completed when assessing a resident with a change in health status. It can provide valuable information that could have been used to assess ongoing hydration. No blood pressure was recorded."

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129. RN C did not assess or monitor Mrs A’s condition adequately in line with nursing competencies, sector standards, or the rest home procedure for registered nurse assessment. These all stress that assessments should reflect the needs and health status of the resident. RN C did not perform the basic observations that I would expect all registered nurses to undertake in circumstances such as these.

130. I accept and agree with Ms Bish that “[a]ssessment, monitoring and evaluation of Mrs A’s vital signs and condition were inadequate and could be considered a severe departure from accepted practice”. Accordingly, I find that RN C did not provide services with reasonable care and skill to Mrs A and breached Right 4(1) of the Code.

Obtaining medical review — Breach

131. Mrs A exhibited respiratory symptoms and vomiting, diarrhoea, and hydration and nutritional issues in the period from Day 1 to Day 10.

132. On Day 6, RN C contacted the GP requesting a prescription for anti-diarrhoeal medication, but provided no other information to the GP, and did not request a medical review of Mrs A. RN C did not seek further input from the GP until he made an appointment for the GP to see Mrs A on Day 10. Before this could occur, Mrs A was admitted to hospital.

133. In my view, on Day 6, when Mrs A’s condition was not improving, there was an onus on RN C to seek medical advice in accordance with nursing competencies and rest home policy. He did not do so in an appropriate or timely manner. Furthermore, on the evening of Day 9, when Mrs A had another episode of diarrhoea, medical advice was still not sought despite Ms E clearly indicating her concerns to RN C. As a result, no medical assessment or diagnosis was obtained between Day 1 and Day 10 despite multiple entries in the records that Mrs A was unwell. Ms Bish advised that this was a severe departure from standards. In my opinion, the management of Mrs A’s symptoms was inadequate, and RN C breached Right 4(1) of the Code.

Care planning and evaluation of care — Breach

134. A long-term care plan had been put in place in September 2010. A complete evaluation of the care plan was completed within six months, in February 2011 (as required by the Aged Related Residential Care Services Agreement). Some, but not all, aspects of the care plan were later reviewed (nutrition and hydration in March 2011 and skin integrity in July 2011), but a further complete evaluation was not completed in the next six-month period as required.

135. When Mrs A became unwell, no short-term care plans were completed by RN C to provide instructions to caregivers on care requirements and monitoring. Ms Bish considered this to be a moderate departure from accepted practice.

136. Short-term care plans help to ensure that registered nurses carry out and document the care required by a resident. Much of the day-to-day care at rest home facilities is carried out by caregiver staff. It is crucial, in my view, that documentation and instructions to staff in the form of care plans are clear, reflect residents’ needs, and are easily accessible by all staff. This did not happen in Mrs A’s case. Nursing and sector

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standards emphasise the need for planned nursing care. In my opinion, care planning for Mrs A was inadequate and, as a result, RN C failed to provide services to Mrs A with reasonable care and skill. Accordingly, I find that RN C breached Right 4(1) of the Code.

Documentation and recording of actions — Breach

137. Between Day 3 and Day 10, staff reported regularly on Mrs A's condition. Although RN C was not working at the rest home on Days 3, 7 and 8, and was working as a caregiver on Day 9, he was aware of Mrs A's condition from Day 4 onwards. RN C made entries in Mrs A's progress notes on six occasions in this period, but failed to record particular actions.

138. On Day 6, RN C documented that loperamide had been given, but he made no record on the "PRN medicines" part of the medication chart that he had faxed a request for prescription of the medication.

139. RN C placed an isolation notice on Mrs A's door as an infection control precaution, but did not document any instructions to staff regarding potential precautionary measures.

140. On Day 9, there is no record of Mrs A's energy drink intake, which should have been documented in light of her vomiting and diarrhoea. On Day 10, RN C telephoned the GP clinic to arrange an 11am appointment, but this was not documented.

141. I agree with Ms Bish's advice that RN C's documentation was inadequate. Ms Bish advised that this could be considered a severe departure from accepted practice. In my opinion, RN C's documentation did not comply with professional nursing standards and, accordingly, he breached Right 4(2) of the Code.

142. As a result of this poor documentation, important information about Mrs A's condition was not available to the entire team caring for her. This, in tandem with RN C's lack of short-term care plans — which have an inherent communicative function — meant that he did not provide important information about changing clinical circumstances to other staff, and this contributed to the lack of continuity in Mrs A's care. Accordingly, I find that RN C breached Right 4(5) of the Code.

Adverse comment — Ms E

143. Caregiver Ms E told HDC that when she returned from ten days' leave on the Sunday morning shift of Day 9 she was "shocked" to see the deterioration in Mrs A's condition. Ms E documented that Mrs A was very unwell, had lost weight, could not walk without staff assistance, that Mrs A had been unwell for about a week, and that she felt that Mrs A needed to see a GP. I note that although RN E's response indicates that she appeared sufficiently concerned to purchase energy drink for Mrs A, and that

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she recalled Mrs A drinking about 850ml over her shift without vomiting or having diarrhoea, she made no record of this in the notes.

144. The rest home's "Policy on Unwell or Injured Residents" states that if a resident is found to be ill or injured, then the staff member will protect the resident's safety, call other staff for help, stay with the resident or call the registered nurse in charge or on call, reassure the resident until the registered nurse arrives, administer first aid as able, and then provide details of the resident's illness to the registered nurse on arrival at the rest home.

145. Although RN C was due on duty that afternoon, I would have expected an experienced caregiver such as Ms E, upon recognising Mrs A's deterioration, to have sought some form of clinical advice or assistance immediately, to have considered whether to call an ambulance, and to have documented all of her actions.

Opinion: Beta Pacifica Corporation Limited

146. While I have identified the distinct deficiencies in care provided by RN C, I remain mindful of the context in which his substandard care was provided. Beta Pacifica had a responsibility, in line with the New Zealand Health and Disability Sector Standards (see above), to operate the rest home in a manner that provided residents with timely, appropriate, and safe care.[28]

147. I acknowledge that Beta Pacifica had difficulty recruiting appropriately skilled clinical staff. However, when RN C commenced employment he was a newly graduated registered nurse and had had virtually no experience working as a registered nurse. He had not been in a position to access a nursing graduate preceptor or to participate in the DHB's "Nurse Entry to Practice Programme" through the rest home. However, I note that this is not an obligation on the employing company. It was appropriate that initially RN C was supervised clinically by the Clinical Services Manager, RN D.

148. Beta Pacifica advised that RN D ceased her employment when RN C had been employed for around three months. Mr H, the General Manager of Beta Pacifica, told HDC that no arrangements were made to replace the Clinical Services Manager.

149. Ms Bish has advised that the decision to reduce the registered nurse hours available at the rest home following the resignation of the Clinical Services Manager was contrary to staffing level recommendations; concerns raised by RN C about staffing; and the Age Related Residential Care Services Agreement.[29]

[28] See Opinion 11HDC00940, 28 November 2013, available at www.hdc.org.nz.
[29] Section D17.3 b.

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150. The rest home had 21 rest home level residents at the time of these events. Ms Bish has advised that the *Indicators for Safe Aged-care and Dementia-care for Consumers*[30] recommends 1–2 hours of registered nurse input per week for each resident assessed as requiring rest home level of care. In the rest home's case, this equates to 42 hours.

151. RN C said that he told Beta Pacifica management of his concerns about the lack of a clinical services manager and his clinical supervision. Although RN C's three-month appraisal did not specifically detail his concerns, this appraisal (performed by a non-clinical staff member) was completed only five days after RN D ceased employment. As Ms Bish advised, it was not appropriate for an unqualified facility manager to perform an appraisal of clinical care. RN D also told HDC that she recalled that RN C had voiced concerns about clinical supervision. I am of the view that it is more likely than not that RN C brought his concerns to the attention of Beta Pacifica.

152. With regard to the arrangements made to supervise the progress of RN C after the Clinical Services Manager resigned, Beta Pacifica told HDC that the rest home had an "informal arrangement with [a third facility] where clinical support and advice could be accessed if requested". I have been provided with no evidence of any arrangement in place, formal or informal, to supervise RN C clinically at that point. In my view, having no formal clinical supervision arrangement in place for a very inexperienced registered nurse was inadequate.

153. I agree with Ms Bish that at this time Beta Pacifica did not make sure that there was an appropriate staffing and skill mix in place to meet residents' needs. Expecting RN C to care for rest home residents without clinical supervision was unreasonable and unsafe owing to his relative inexperience, and placed the residents and RN C at risk. Ms Bish advised that "the lack of appropriate supervision, RN staffing hours and skill mix leading up to [Mrs A's] change in health status and hospitalisation undoubtedly contributed to inadequate clinical reasoning and would be considered a severe departure from accepted practice".

154. As stated recently, the New Zealand Health and Disability Sector Standards require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to ensure the provision of timely, appropriate, and safe services to consumers.[31] Beta Pacifica had ultimate responsibility to ensure that Mrs A received such care. The systems within which a team operates must enable provision of an appropriate standard of care to residents.

155. I consider that by not having an appropriate staffing and skill mix in place to meet residents' needs, Beta Pacifica Corporation Limited did not take sufficient steps to ensure that appropriate systems were in place to provide services to Mrs A with reasonable care and skill. Therefore, in my view, it breached Right 4(1) of the Code.

[30] Standards New Zealand, Indicators for Safe Aged-care and Dementia-care for Consumers (2005).
[31] Opinion 11HDC00940, 28 November 2013, available at www.hdc.org.nz.

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156. I am concerned that, despite the instruction in the detailed long-term care plan, dated 10 September 2010, Mrs A's vital signs and weight were not recorded regularly by staff as required, and therefore Mrs A was not being monitored appropriately. I am also concerned that caregiver staff, when faced with Mrs A's deteriorating condition, did not contact the on-call registered nurse in line with policy, or seek assistance. This was contributed to by the lack of an explicit process for accessing medical services out of hours. As stated previously,[32] the inaction of multiple staff to adhere to policies and procedures points toward an environment that does not support and assist staff sufficiently to do what is required of them.

157. Rest-home owners have an organisational duty of care to provide a safe health-care environment for its residents.[33] This duty of care includes ensuring that staff work together and communicate effectively, ensuring that policies and procedures are consistent with relevant standards, and ensuring that staff comply with policies and procedures.[34] By failing to ensure that staff were complying with policies and procedures, Beta Pacifica Corporation Limited failed to comply with the Health and Disability Sector Standards and breached Right 4(2) of the Code.

Recommendations

158. I recommend that Beta Pacifica Corporation Limited, in light of this report:

- Provide a formal written apology to Ms B and her family for its breaches of the Code. The apology is to be sent to HDC within three weeks of issue of this report, and it will be forwarded to the family.
- Develop a system, for implementation in all of its aged residential care facilities, of multidisciplinary morbidity/mortality review of residents who become seriously unwell and/or are transferred to hospital or die in their care. The review system developed should be provided to HDC and the Ministry of Health within three months of issue of this report.
- Introduce the Registered Nurse Care Guide for residential aged care, and the Caregiver Guide for residential aged care,[35] for implementation in all of its aged residential care facilities. The guides contain relevant evidence-based practice management for residential care.
- Conduct a full review of policy and procedure at all facilities it operates.
- Develop and provide HDC with a clear and comprehensive set of updated and co-ordinated policies and procedures, which should include policies that govern:

    1. staff accessing medical care after hours and in emergencies;

[32] Opinion 09HDC01783, 2 May 2011, available at www.hdc.org.nz.
[33] See Opinion 11HDC00423, 27 June 2013, available at www.hdc.org.nz.
[34] See Opinion 08HDC17309, 26 May 2010, available at www.hdc.org.nz.
[35] See http://www.waitematadhb.govt.nz/HealthProfessionals/RACIPcareguides.aspx.

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2. the effective use of short-term care plans; and
3. steps that will be taken to ensure staff compliance with policies and procedures.

159. I recommend that RN C:

- Provide a formal written apology to Ms B and her family for his breaches of the Code. The apology is to be sent to HDC within three weeks of issue of this report, and it will be forwarded to the family.

- Provide HDC and the Nursing Council of New Zealand with full details and documented evidence of all professional nursing supervision, mentoring activities, and educational development he has undertaken to meet registered nurse competencies as a result of this matter. The matter will be referred to the Nursing Council of New Zealand (NCNZ) for its consideration of a competence review and continued evaluation of RN C.

Follow-up actions

160.
- A copy of this report with details identifying the parties removed, except Beta Pacifica Corporation Ltd and the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

- A copy of this report with details identifying the parties removed, except Beta Pacifica Corporation Ltd and the expert who advised on this case, will be sent to the DHB and the DHB within whose region RN C now works, and these organisations will be advised of RN C's name.

- A copy of this report with details identifying the parties removed, except Beta Pacifica Corporation Ltd and the expert who advised on this case, will be sent to the College of Nurses Aotearoa Inc, and HealthCERT (Ministry of Health), and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent nursing advice to HDC

The following expert advice was obtained from an independent nursing advisor, Ms Tanya Bish:

"I, Tanya Bish, have been asked to provide expert advice on case **C11HDC01197**

Qualifications

2012 Postgraduate Master of Nursing (Hons)

2010 Postgraduate Diploma in Health Sciences (with Distinction)

2008 Postgraduate Certificate in Health Sciences

1996 Levels One and Two of the Infection Control Practitioners Certificate Course

1993 Certificate in Gerontological Nursing

1992 Bachelor of Commerce Degree

1987 New Zealand Registered Comprehensive Nurse

Professional membership

NZNO Infection Control Division, Gerontology Division
College of Nurses Aoteoroa

Experience

Over 25 years gerontological nursing, management and consulting experience predominantly in residential aged care.

Two years working as a Gerontology Nurse Specialist in the community Waitemata District Health Board (WDHB).

Four years working as a Quality and Professional Development Nurse Leader for Residential Aged Care WDHB.

Advice requested

To provide expert advice, with reference to professional nursing standards and competencies, and sector standards where appropriate, from the information provided on:

1. The overall standard of the care provided to [Mrs A] at [the rest home];
2. The standard of the assessment, monitoring and evaluation of [Mrs A's] vital signs and condition;
3. The standard of documentation and recording of actions and progress;
4. The standard of the management of [Mrs A's] respiratory symptoms, vomiting and diarrhoea, and her hydration and nutrition;
5. The standard of care plans and evaluation of care for [Mrs A];
6. The monitoring of [Mrs A's] food and fluid intake;
7. The standard of communication between staff and GP (Dr F);

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8. The standard and appropriateness of [the rest home's] policies and procedures, including specific reference to its policies on access to medical care outside of normal business hours;
9. The appropriateness of RN and caregiver staffing and experience levels present at [the rest home] [at this time];
10. The appropriateness of the arrangements made to direct, supervise and clinically monitor the progress of [RN C after the Clinical Services Manager had left the employment of Beta Pacifica];
11. The appropriateness of remedial actions taken by [the rest home] as a result of the complaint;
12. Any aspects of the standard of care provided by [RN C] and [the rest home] that warrant additional comment;
13. The degree of severity of any departures identified.

Information reviewed

1. [Ms B's] complaint and supporting material;
2. Response to HDC from Beta Pacifica Corporation Ltd dated 19 January 2012 incorporating
   a. Beta Pacifica correspondence with [Ms B] dated […];
   b. [Mrs A's] progress notes and residential lifestyle plan;
   c. A draft investigation report;
   d. Correspondence from Beta Pacifica received from [the] DHB.
3. Correspondence from Beta Pacifica to [Ms B] dated 15 May 2012 enclosing a finalised investigation report.
4. HDC letters of notification of investigation, dated 21 May 2013;
5. Response to HDC from [RN C], outlined in paragraphs 1–53, dated 25 June 2013, enclosing his RN job description, supporting material, and statements from [RN D] (former Clinical Services Manager) and [Ms E], senior caregiver;
6. Response to HDC from Beta Pacifica Corporation Ltd dated 15 July 2013 including attachments
   a. Correspondence with the Ministry of Health regarding the closure of the facility;
   b. Copies of medication records, and prescription and administration forms for [Mrs A];
   c. [RN C's] staff training, job description, and employment agreement;
7. Further clinical records provided.

I have been advised that details of the preliminary advice provided to the Commissioner, nursing opinion provided in the course of [the] DHB review of [Mrs A's] care, and ACC's review or some references to those advisor's reports have been purposely withheld from documents provided to me.

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Background

[Mrs A] was admitted to [the rest home] [in] 2009, at the age of 81 years. [Mrs A] was noted to have chronic obstructive pulmonary disease, congestive heart failure, ischaemic heart disease, hypothyroidism and osteoarthritis of her left hip.

On [Day 1], the nursing progress notes record that [Mrs A] was unwell with a heavy cold. It appears that [Mrs A] may also have been suffering with diarrhoea, as five days later, a care assistant noted '[Mrs A] still has diarrhoea'.

On [Day 6], [RN C] assessed [Mrs A], noting her temperature was 36.2°C, and recorded her pulse and pulse oximetry reading. That afternoon [RN C] contacted the GP and requested a prescription for Loperamide for [Mrs A]. [RN C] instructed staff to keep [Mrs A] in her room.

Over the next 3 days, [Mrs A] had further episodes of diarrhoea, vomited and was refusing food and fluids. She asked twice to be transferred to hospital, and a caregiver wrote that [Mrs A] had been unwell for a week and needed to be seen by the GP.

[RN C] noted on the afternoon of [Day 9], that [Mrs A] was 'very ill', had severe diarrhoea, and was to be encouraged to drink to prevent dehydration.

On [Day 10], [Mrs A] was admitted to [Hospital]. She died [three days later]. Cause of death was noted to be congestive heart failure 6 days, dehydration 8 days, and diarrhoea 9 days.

Follow up

[Ms B complained] to the rest home Facility Manager, MOH, HealthCERT, and [the] DHB about the services provided to her grandmother.

[Another rest home company (the company)] investigated [Ms B's] complaint about the rest home for Beta Pacifica. [The company] placed a new manager at the rest home who was tasked with providing an 'Escalation path' and documentation training for the rest home staff, and clinical oversight. [RN C] was placed in another Beta Pacifica facility for further education and training.

[The] DHB arranged for its Director of Nursing to review the service the rest home provided. She made a number of recommendations which included, providing [RN C] with clinical supervision at another residential care facility owned by Beta Pacifica. The DHB met with Beta Pacifica General Manager [Mr H] to discuss the review report. [Mr H] met [Ms B] and her father to discuss their concerns.

[The] DHB wrote to [Ms B], advising that, following DHB review, a series of recommendations were made to Beta Pacifica. The DHB advised [Ms B] that the DHB and MOH would continue to monitor the rest home, and an unannounced audit of the facility was planned.

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On 19 January 2012 [Mr H] apologised to [Ms B] in writing, and attached a copy of [the company's] investigation report. On 3 April 2012, [Mr H] met with [Ms B] again to discuss her comments on [the report].

The following standards/evidence based guidelines/contracts are relevant to this case:

- Health and Disability Sector Standards NZS 8143:2008
- Health Practitioners Competence Assurance Act 2003
- Age-related residential-care services agreement 2011
- The Code of Health and Disability Services Consumers' Rights 2009
- New Zealand Nursing Council Registered Nurse (RN) Scope of Practice and Competencies
- New Zealand Handbook Indicators for Safe Aged-care and Dementia-care for Consumers SNZ HB 8163:2005

1. Standard of care provided to [Mrs A] at [the rest home]

[Mrs A] (81 years) was assessed as requiring rest home level care in 2009. At this level of care, assessment, care-planning, direction and delegation of care are carried out by a registered nurse (RN) but a registered nurse is not required to be on duty at all times. An 'on call' contact is required for staff to be able to contact for clinical advice and support as required.

From the progress notes there is evidence that [Mrs A's] condition began to deteriorate on [Day 1]. Initial symptoms reported in the progress notes were coughing, runny nose and 'lost voice'. Later diarrhoea and loss of appetite were also reported. On [Day 7] it is reported that [Mrs A] believed she should be in Hospital. [Ms B] recounts that her grandmother stated that she had requested to be seen by a doctor and also stated that they shouldn't have let her get this sick. Caregivers working on [Days 1, 2, 3, 7, 8 and 9] noted a deterioration in [Mrs A's] health status when the RN was not on duty but there is no evidence that they contacted the RN on call. The RN became aware of [Mrs A's] change in health status on the [Day 4]. Whilst a General Practitioner was contacted on [Day 6], regarding diarrhoea, no on-site medical assessment was completed and [Mrs A] continued to deteriorate. [Mrs A] was placed in isolation by [RN C] due to potential risk of norovirus but no specimen was taken. With regards to the isolation, this degree of caution was appropriate given the cause of the diarrhoea had not been confirmed and therefore the potential risk to other residents. It would have been advisable to collect a faecal specimen for laboratory analysis to assist in the identification of the cause of the diarrhoea. Previous discussions had taken place with [Mrs A] regarding her wishes, advance care planning and care at the end of life. It was documented in the care plan 28 February that [Mrs A] wished to go to Hospital if she was dying. Her wishes were carried out on [Day 10] but the delay in seeking medical attention may have contributed to her death [three days later]. Given [Mrs A] had made her wishes known and that she was unwell the

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delay in seeking medical assessment could be considered a severe departure from accepted practice.

2. Assessment, monitoring and evaluation of [Mrs A's] vital signs and condition

Health and Disability Sector Standards NZS 8134:2008 require that consumers receive services that meet their individual assessed needs, that assessment is undertaken by a suitably qualified service provider, assessment is developed in partnership with the consumer and/or family and is documented to a level of detail required to demonstrate the needs of the consumer.

[RN C] was aware that [Mrs A] was unwell [Day 4] and as the Registered Nurse for the Rest Home was responsible for assessing [Mrs A] due to her change in health status. [Mrs A's] temperature (T) was checked and reported to be 37°C. It was noted that she did not want her breakfast but did have a cup of tea and lunch. Assessment is minimal and no short term careplan is evident to inform the caregivers of monitoring or interventions required. The following day [Mrs A] was reported to be feeling better in the morning but not the afternoon and night staff reported that she was not feeling well. Further vital signs were recorded by [RN C] on [Day 6], T 36.2°C, pulse 66. A report of 'resp 98%' is likely to indicate that a pulse oximetry recording was taken registering 98% oxygen saturation on air. No blood pressure recording or respiratory rates are reported in the progress notes. Comments were made that there was no cough, sore throat or signs of chest infection. [Mrs A] was placed in isolation by [RN C] due to potential risk of norovirus but no specimen was taken. With regards to the isolation, this degree of caution was appropriate given the cause of the diarrhoea had not been confirmed and therefore the potential risk to other residents. It would have been advisable to collect a faecal specimen for laboratory analysis to assist in the identification of the cause of the diarrhoea. On [Day 8] the caregiver wrote 'All in all she is feeling very miserable. ? needs to see a doctor.' On [Day 9] she is also reported to be very unwell and needing to see a doctor. That evening [RN C] reports that she is 'very ill on bed, not eating her dinner, had small amount of soup and tea. RN encouraged her to drink some water to prevent dehydration, she had about 200mls water, afterwards she vomited but keep encourage her to drink water.' No vital signs are recorded, medical attention is considered but not actively sought. [RN C] felt that a doctor would not visit at the weekend and decided to make an appointment for [Mrs A] the following morning. On [Day 10] she is transferred to hospital before her scheduled medical appointment at 1100hrs as [RN C] was concerned about her deteriorating health status. [RN C] wrote this was due to 'her terrible flu'.

There was no evidence that all vital signs were taken regularly when [Mrs A] was known to be unwell. No short term care plan was evident. Assessment, monitoring and evaluation of [Mrs A's] vital signs and condition was inadequate. [RN C] notified [Ms B] of her grandmother's condition and pending transfer to hospital [Day 10] but [Ms B] was unaware of her deteriorating condition prior to this. There is no evidence that [Mrs A] was asked if she would like family to be

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contacted when she became unwell despite her careplan stating ‘In cooperation with [Mrs A], ensure that her family are kept well-informed about any change in health status.’

Assessment, monitoring and evaluation of [Mrs A’s] vital signs and condition were inadequate and could be considered a severe departure from accepted practice.

3. Documentation and recording of actions and progress

Staff reported regularly on [Mrs A’s] deteriorating condition however inadequate assessment, monitoring and interventions were initiated or reported on in the clinical file. Documentation of vital signs, fluid intake/output, assessment, monitoring, short term care planning, verbal phone order for loperamide, monthly doctors visit exemption, communication with family and interdisciplinary communication were inadequate. Loperamide was signed for on the signing sheet but there was no record of a verbal phone order under the ‘PRN medicines’ on the medication chart provided. Whilst the policy states there will be no phone orders and that the medication chart will be faxed there is no evidence of the order on the medication chart other than on the administration record.

This inadequate documentation could be considered a severe departure from accepted practice.

Management of respiratory symptoms, vomiting, diarrhoea, hydration and nutrition

Due to [Mrs A’s] advanced age and multiple comorbidities assessment and diagnosis may not have been straight forward. Whilst symptoms of illness were reported medical diagnosis is not in the scope of practice of a newly registered nurse. The RN identified the risk of dehydration and was attempting to provide adequate hydration but no fluid intake chart appears to have been initiated. The RN contacted the GP regarding diarrhoea and it is stated a prescription was forwarded but there is no evidence that the GP assessed [Mrs A] or requested further information or monitoring. No evidence was found that a review for the need for frusemide was completed given the potential dehydration due to diarrhoea and lack of appetite. Diagnosis and therefore treatment was inadequate and could be considered a severe departure from accepted standards.

4. Care plans and evaluation of care

A care plan was documented by the clinical manager, [RN D], in September 2010. An evaluation of the care plan was completed in February 2011. The care plan states ‘Document any changes observed in [Mrs A’s] progress notes and inform the RN with any concerns; [Mrs A’s] health status to be reviewed by her GP at least 3/12; in cooperation with [Mrs A], ensure that her family are kept well informed about any changes in health status’.

These directions were not fully carried out. Although there are some aspects of the care evaluated after February 2011 a complete care plan evaluation was not

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completed in the six month timeframe required. No short term care plan was documented when she became unwell. This could be considered a moderate departure from accepted practice.

5. Food and fluid intake monitoring

[Ms B] reported that [a doctor] had informed her that her grandmother had arrived at hospital 'very badly dehydrated' and that she may not survive.

[Ms B] stated that she was surprised to see how much weight her grandmother had appeared to have lost in 8 weeks since last seeing her.

Caregiver, [Ms E], is reported as stating that [Mrs A] had not been eating for 12 days, was unwell and should have been seen by a doctor.

There is clear evidence that [Mrs A] was acutely unwell during the days leading up to hospital admission and that she had a loss of appetite. Staff were reporting in the progress notes about her poor appetite and there is evidence that staff encouraged food and fluid but it is not surprising that she was not maintaining her nutrition and hydration due to her deteriorating health status.

6. Communication

The standard of communication amongst the interdisciplinary team was inadequate to ensure safe and effective care in line with [Mrs A's] wishes. Caregivers did not contact the RN on call when there was a change in health status. [RN C] did not request medical assessment in a timely manner despite [Mrs A's] deteriorating condition. [Dr F] did not ascertain whether further medical assessment was necessary when notified by [RN C] of diarrhoea. This could be considered a severe departure from accepted practice.

7. Policies and procedures

The 'Procedure for Transfer of Resident to Hospital' applies to situations where the RN and GP have decided to transfer a resident to Hospital. The procedure is appropriate.

The 'Policy on Unwell or Injured Residents' states that the staff member will call the Registered Nurse in charge or on call and provide details of resident's illness to the Registered Nurse on their arrival. This is standard practice and is appropriate. It is reported that [Mrs A] had a change in health status from [Day 1]. [RN C] became aware that [Mrs A] was unwell [Day 4]. According to procedure the RN should have been notified when the resident was 'found to be ill …'. There was a delay in the RN becoming aware of [Mrs A's] change in health status.

Page 2 of the policy refers to the 'Procedure for Registered Nurse Assessment'. It outlines the requirement to initiate First Aid/Treatment, instruct caregivers, gather documented information, complete further assessment according to priority and the need to decide whether the Dr's advice is needed. The progress notes indicate a brief assessment 'RN checked [Mrs A] this morning. She complain she lost her

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voice. OB taken T=36.2°C, pulse 66, Resp 98%. No cough, no sign of chest infection. No sore throat. She said she just feeling unwell, very tired, lemon drinks offered. She had her morning tea but doesn't want her dinner. She just want stay in bed for rest.' In the procedure there is a list of possible things to assess including 'Blood Pressure' which is considered a vital sign and would usually be completed when assessing a resident with a change in health status. It can provide valuable information that could have been used to assess ongoing hydration. No blood pressure was recorded. If it is deemed that the Dr's advice is needed it requires the RN to contact the Doctor for the advice on treatment or transfer to hospital. In this case, whilst it is reported the GP was contacted on [Day 6] regarding [Mrs A's] diarrhoea, no on-site medical assessment was completed and [Mrs A] continued to deteriorate.

Page 3 of the policy refers to the 'Procedure for Contacting Duty Doctor' and requires that 'all relevant detail is on hand before contact is made' including documentation, 'history of current illness' and 'recordings from current assessment'. It is required that the RN record the advice provided. [RN C] wrote 'RN contacted GP to charted some Nodia (Loperamide) tabs for her loosing bowels'. There is no information regarding what information the Doctor was provided with other than diarrhoea.

Page 4 describes the 'Procedure for Recording Duty Doctor Verbal Instructions' which requires that the RN repeat back the verbal instructions to establish accuracy. The 'Policy on Visits by Medical Practitioners' stated there will be 'no verbal medication orders' and that the medication chart must be faxed to the GP who will record any changes. Despite this there is no signed order for loperamide on the medication chart provided.

The 'Policy on Visits by Medical Practitioners' states 'Each on call emergency medical services must be available 24 hours a day'. It is also noted that [RN C] states in correspondence to the Health and Disability Commissioner 25 June 2013 that 'I could not get a doctor to visit on the weekend.' There is no copy of the signed Contract for Medical Services so it is unclear what the 'after hours medical cover' arrangements were and why [RN C] felt that a doctor's visit would not be available at the weekend. It is also unclear whether this statement also applied to medical advice per phone. In the absence of contracted medical services [RN C] did have the option of calling an ambulance but this option was not taken until the following morning.

8. Staffing and skill mix

[The rest home] had 21 residents during [this time]. The Indicators for Safe Aged-care and Dementia-care for Consumers recommends 1–2 hours Registered Nurse input per week for each resident assessed as requiring rest home level of care. This equates to a maximum of 42 hours per week. The decision to reduce the Registered Nurse hours available to the rest home [following the retirement] of the Clinical Manager was contrary to the staffing level recommendations, the advice

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of the Registered Nurses currently and previously employed and the Age Related Residential Care (ARRC) Agreement.

The ARRC agreement 2011 states the following:

D17.2 If you receive notification from any Person that may raise a doubt about the safety of the services provided by a Health Practitioner employed or contracted by you, including but not limited to notification from a Responsible Authority that the Responsible Authority has reason to believe that a registered Health Practitioner employed or contracted by you may pose a risk of harm to the public, you must take all action that is appropriate in the circumstances to ensure the care and treatment provided by the Health Practitioner to Subsidised Residents is safe and is of an appropriate standard.

D17.3 Rest Homes

Despite clause D17.3(a), where (having regard to the layout of the Facility, the health and personal care needs of Residents and the ease with which the Residents can be supervised) the Registered Nurse or Manager at any time considers that additional staff are required to meet the needs of all Subsidised Residents, you shall ensure that those extra staff are On Duty for the period of time that the Registered Nurse or Manager recommends.

(d) Manager

i. Every Rest Home must engage a Manager who holds a current qualification or has experience relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Rest Home; and
ii. The role of the Manager includes, but is not limited to, ensuring the Subsidised Residents of the Home are adequately cared for in respect of their everyday needs, and that services provided to Subsidised Residents are consistent with obligations under legislation and the terms of this Agreement.

It was the Manager's responsibility to ensure the staffing and skill mix was appropriate to meet the resident's needs. The manager was aware that [RN C] was newly registered and therefore had limited experience as a Registered Nurse. [RN C] states that he had discussed his concerns regarding clinical supervision with the facility Manager, [Ms G]. Expecting [RN C] to cover rest home residents without a preceptor or supervision was unreasonable and placed the residents and the nurse at unacceptable risk. He was also expected to be on call without a break for the duration of the time when he was the only Registered Nurse employed to cover two rest homes, reported to care for up to approximately 50 residents. This was unsafe due to his relative inexperience and an unreasonable expectation.

The manager is reported to hold no Registered Nurse or General Practitioner qualification and therefore was not qualified to provide advice on clinical matters.

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The lack of appropriate supervision, RN staffing hours and skill mix leading up to [Mrs A's] change in health status and hospitalisation undoubtedly contributed to inadequate clinical reasoning and would be considered a severe departure from accepted practice.

9. RN supervision

When [RN C] started working at the rest home in April 2011 he had a senior RN, Clinical Manager, available for advice and support. This was appropriate given his level of experience and recent graduation. Unfortunately after 3 months the situation changed and he became relatively clinically isolated. New graduate programmes recommend a qualified RN preceptor be available to a new graduate during their first year of practice to enable them to embed their knowledge and skills. [RN C] states that he had discussed his concerns regarding clinical supervision with the facility Manager, [Ms G], and that he felt obliged to continue his employment.

According to [RN C's] job description, by which he was bound on 28 April 2011, his reporting requirements were to inform 'the Clinical Manager of any significant issues'. This document was authorised by the Nurse Manager and the Facility Manager July 2010 however no new arrangements were put in place [when] there was no longer a Clinical Manager to report to. The policy for 'Direction and Delegation' states that Performance Appraisals are used to assess if staff work within their scope of practice. [RN C] had an appraisal 3 months from the date of commencing employment however this was completed by the facility Manager and not a clinician. It is not appropriate for a manager without nursing or medical registration to provide feedback on clinical competency in relation to their scope of practice. A clinical performance appraisal would have provided valuable information on his skill, expertise and competency at the time that the clinical supervision was no longer available. In the 'Summary of Staff Appraisal', the appraiser (Facility Manager, [Ms G]) states 'the work hours have been a real challenge. [RN C] had a lot of pressure from the previous clinical manager. These will now change. New RN sharing on call will start on [Day 3]. Each RN will be required to work 40hrs a wk and 1 on call weekend (every other)'. Whilst this appointment may have addressed the inadequate RN hours to cover two rest homes it did not address the lack of clinical supervision. It is also noted that the job description required the RN to deputise for the Clinical Manager as required. [RN C] was not deputising for the Clinical Manager as there was no Clinical Manager at the time these events occurred. There is evidence to suggest that the decision not to replace the Clinical Manager was not one he concurred with. [RN C] alleges that it was the Facility Manager, [Ms G], who made the decision not to recruit a Clinical Manager despite [RN C] 'plead[ing] with her to address the issue of the lack of a Clinical Services Manager'. There is no evidence that [RN C] was employed as the Clinical Manager following the resignation of [RN D], the previous Clinical Services Manager. The employment situation left him with a choice to resign, potentially risking the career he had chosen or continue his employment without a senior RN to refer to. It is likely that having to make this choice placed him under significant stress.

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New graduates require time to consolidate their learning and develop confidence. It would appear that [RN C] has gained further experience with time but should not have been expected to take the level of responsibility asked of him following the retirement of the Clinical Manager. It is unfortunate that [RN C] agreed to accept this degree of responsibility however it is also evident that there were extenuating circumstances which placed the employer in a position of power that was not used responsibly. If [RN C] had resigned he would have lost his Registered Nurse position.

The arrangements made to direct, supervise and clinically monitor the progress of [RN C] [after the Clinical Services Manager had left the employment of Beta Pacifica] were inadequate and could be considered a severe departure from accepted practice.

10. Remedial actions taken by the rest home

It would appear that following this incident, the advice, given by [the DHB's] Director of Nursing, to provide [RN C] with clinical supervision at another residential care facility owned by Beta Pacifica was followed as evidenced in the signed agreement to undertake 'Secondment to [the third facility]' dated [late] 2011. It is less clear what other remedial actions were requested or whether Nursing Council was notified of potential concerns related to the care provided by [RN C] as not all previous investigations have been made available for this expert advice. It is noted the facility has since closed.

Summary of key points and opinion

The evidence provided indicates the routine care of [Mrs A] between [Day 1] and admission to Hospital [Day 10] were inadequate. This was due to multiple failures. The decision made to leave a new graduate nurse without clinical supervision responsible for direction and delegation of care for Rest Home residents with a high level of need was inappropriate and placed both the residents and the Nurse at risk. Assessment, monitoring, care planning, evaluation and documentation were insufficient to meet [Mrs A's] needs when her health status changed. The expectation that [RN C] provide services to two Rest Homes reduced the overall hours available to the residents at the rest home and is likely to have impacted on the ability to maintain the required standard of assessment, care planning, evaluation and documentation. The delay in seeking medical treatment may have impacted on [Mrs A's] potential recovery and/or comfort at the end of her life. The delay in notifying family resulted in them not being available to provide support to [Mrs A] and was contrary to her wishes according to her care plan. Overall there were severe departures from accepted practice in this case.

Signed,

Tanya Bish NZRCompN, MN (Hons)"

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