Rest-home Company

Registered Nurse, RN C

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC00217)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man, aged in his eighties, at a rest home during his admission for respite care. The report highlights the importance of aged-care facilities ensuring that all new admissions are assessed by suitably skilled clinical staff in a timely manner.

2. The man was admitted to the rest home in 2016. He had a history of metastatic melanoma. An enrolled nurse both conducted his initial assessment and prepared his care plan. There is no documentation of the man's baseline recordings having been taken at his admission, or of his care plan being reviewed by a registered nurse.

3. The following morning, the man complained to a caregiver that he had abdominal pain and was unable to move, and he refused to go to lunch. The caregiver consulted the registered nurse (the rest home's Clinical Manager and sole registered nurse) about the man's refusal to go to lunch, but the caregiver did not mention his abdominal pain. Later in the day, the registered nurse left the premises without having reviewed the man.

4. In the afternoon, the man's daughter visited him at the rest home and found him to be very unwell. He was taken to hospital by ambulance, and en route ambulance staff found his vital signs to be abnormal. The man was diagnosed with a perforation of his small intestine and, sadly, he deteriorated in hospital and passed away the next day.

Findings

5. The Deputy Commissioner considered that aspects of the man's care were inadequate, including his admission to the rest home and the failure of staff to escalate his abdominal pain to a registered nurse. Accordingly, the Deputy Commissioner found that the rest-home company breached Right 4(1) of the Code.

6. The Deputy Commissioner criticised the registered nurse for omitting to confirm the man's admission documentation, and for not reviewing the man before leaving the premises.

Recommendations

7. The Deputy Commissioner recommended that the rest-home company report back to HDC on its changes to practice; review its assessment, management, and monitoring of pain policies; review its training on orientation; review its training to caregivers on illness assessment and communication; review its staffing levels around registered nurses; and provide a formal written apology to the man's family.

8. The Deputy Commissioner recommended that the registered nurse apologise to the man's family and undertake further education on the subject of delegating responsibility to staff.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by RN C and the rest-home company to her late father, Mr B. The following issues were identified for investigation:

- *Whether the rest-home company provided Mr B with an appropriate standard of care in 2016.*
- *Whether RN C provided Mr B with an appropriate standard of care in 2016.*

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

11. The parties directly involved in the investigation were:

Mrs A	Consumer's daughter/complainant
RN C	Provider/Clinical Manager
Rest-home company	Provider

12. Also mentioned in this report:

Ms G	Caregiver
Ms I	Caregiver

13. Further information was received from EN D (an enrolled nurse), Ms E (a caregiver), Mr F (Mr B's friend), Mrs B (Mr B's wife), the Nursing Council of New Zealand, the ambulance service, the District Health Board (the DHB), and the office of the Coroner.

14. Independent expert advice was obtained from Registered Nurse (RN) Sheryl Lilly (Appendix A).

Information gathered during investigation

Introduction

15. This report concerns the care provided to Mr B by the rest-home company over two days in 2016.

Mr B

16. At the time of events, Mr B was in his eighties. He had a history of metastatic melanoma[1] of the lung, atrial fibrillation,[2] and type two diabetes.[3] At the time of these events, Mr B was in remission for his metastatic melanoma.

[1] A skin cancer that has spread to other sites in the body.

17. Mr B received a NASC[4] assessment from the DHB, which included an interRAI[5] assessment. The assessment stated that Mr B's capabilities were declining, that he struggled to walk and was short of breath, and that he was reliant on his wife to prepare his meals and do the housework. The interRAI assessment noted that Mr B had metastatic melanoma but that he was not receiving active treatment for it.

18. Following the assessment, the DHB agreed to fund 28 days of respite rest-home-level care for Mr B to give his wife some relief as his main caregiver.

The rest home

19. The rest home is a residential care facility[6] owned and operated by a rest-home company. At the time of these events, it was certified by the Ministry of Health to provide rest-home-level care (excluding dementia care) to up to 16 residents, and was contracted by the DHB to provide "[s]hort-term care for older people with a main carer" in "a residential facility for rest home level care to enable main carer to have a break from their caring role". The rest home employed one registered nurse,[7] one enrolled nurse,[8] and eight caregivers,[9] as well as other ancillary staff.

20. In 2015 and 2017, the rest home was audited under the Health and Disability Services (Safety) Act 2001. The 2015 and 2017 audit reports both stated that "staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support". In 2018, the rest home was certified to provide rest-home-level care for three years.

Clinical Manager

21. RN C is the sole Director of the rest-home company, the rest home's Clinical Manager, and the sole registered nurse working at the rest home. Her responsibilities included:

- Ensuring that safe professional nursing care is delivered.[10]
- Managing the facility effectively as a quality continuing care environment.[11]
- Overseeing, and being involved in, the healthcare services provided by the rest home's enrolled nurses and caregivers.[12]

[2] An abnormal heart rhythm that can increase the risk of stroke and heart failure.
[3] A chronic condition that affects the body's processing of blood sugar.
[4] Needs Assessment and Service Coordination assessment.
[5] A Ministry of Health tool that facilitates the sharing of consumers' clinical assessments among healthcare providers. It is targeted at assisting vulnerable people.
[6] An establishment that provides housing and general care for the aged or the ill.
[7] In New Zealand, a registered nurse is a nurse who has passed an examination for registered nurses set by the Nursing Council of New Zealand (among other qualifications).
[8] In New Zealand, an enrolled nurse is a nurse who has passed an examination for enrolled nurses set by the Nursing Council of New Zealand (among other qualifications).
[9] A caregiver is a worker who is not a registered or enrolled nurse.
[10] From RN C's position description.
[11] Ibid.

Admission to the rest home

22. Mr B was admitted to the rest home for two weeks of respite rest-home-level care, funded by the DHB. Enrolled Nurse (EN) D managed Mr B's admission process. As part of the admission process, EN D assessed Mr B's health and needs, and prepared a care plan for him.

23. Mr B's "Initial Assessment on Admission" recorded that he:

- Used a walking frame or stick to walk.
- Had a history of falls.
- Felt "age" related pain, and used paracetamol to address this.
- Breathed adequately, but could become short of breath on exertion.
- Was in remission for melanoma in his lung.
- Did not have special dietary needs.
- Had a visitor attending to his spiritual needs on Wednesdays between 10am and 10.30am.

24. EN D assessed Mr B's risk of suffering from falls as being a "medium risk", based on his falls history and medication. Mr B's "Continence Assessment" recorded that he had diabetes and that he wore an incontinence pad underneath his clothes.

25. Mr B's "Short Term Care Plan" and "Admission Care Plan" recorded that he required help with showering and dressing, and that he needed a walking frame or stick to walk. He spoke slowly, had a history of hallucinations, and felt age-related pain (which he would address with paracetamol at night when necessary). Regarding his dietary needs, the plans stated that he had type two diabetes, but was not recording his blood sugar levels and ate "normally". The plan noted that Mr B expected someone to visit to attend to his spiritual needs between 10am and 10.30am.

26. EN D also documented in the clinical notes:

> "Long spells in hospital. Diagnosed L. Melanoma of lung. Now in remission. [Mr B] tells of period of hallucinations this was vivid and frightening. Diabetic who has been [on] Metformin[13] but this has been stopped. [Mr B] likes his puddings and chocolate. Not on regular BSL.[14]"

[12] From the Nursing Council of New Zealand guidelines *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (May 2011) and *Guideline: delegation of care by a registered nurse to a health care assistant* (May 2011).
[13] A medication used to lower the blood sugar of people with type two diabetes.
[14] Blood sugar levels.

Incorporation of information from the interRAI assessment

27. The "Resident Admission" policy stated:

> "Each resident's personal and health needs are assessed on first admission … This assessment will utilise information gained from the resident, the nominated representative, and that provided by the referring agency and/or previous provider of health and personal care services along with observations and examinations carried out at the facility."

28. The rest-home company told HDC that at the time of these events, RN C incorrectly believed that "only registered nurses were able to access the interRAI tool". EN D did not have access to Mr B's interRAI assessment when conducting her initial assessment of him, so the interRAI did not inform Mr B's assessment or care plan.

Baseline recordings

29. The "Recordings" policy specified: "Base recordings are taken on admission and recorded on admission forms." However, there is no evidence in Mr B's admission forms or other records that EN D took baseline observations. The rest-home company told HDC that EN D "believes she did take [Mr B's] baseline recordings, but that she may have recorded them somewhere other than the admission form".

30. RN C acknowledged that "baseline observations were not recorded on [Mr B's] form", and told HDC that "this is a breach of the Home's policy".

Review of care plans by a registered nurse

31. The "Care Plans" policy required: "On admission a nursing assessment is undertaken by a suitably qualified registered nurse."

32. There is no documentation of RN C having read or reviewed Mr B's care plan. RN C told HDC that it is her "normal practice to create the care plan herself, or where the care plan was written by an enrolled nurse, to co-sign the plan within 24 hours", and that "it would have been her intention to complete this on her next duty on the night of [Day 2][15]". RN C also told HDC that she is "sure that she read and reviewed the care plan for [Mr B]". As noted below, RN C was on duty between 11pm on Day 1 and 7am on Day 2, and left the premises between midday and 1pm that day.

Observations (Day 1)

33. By 4.30pm, Mr B had begun settling in to the rest home. At this time, Ms G, a caregiver, visited Mr B in his room. She recorded in Mr B's progress notes:

> "4.30: Using urinary b4 T time emptied x 2 — gave face wash hands — b4 supper time — bottom ½ wash dry in ensuite b4 bed said hadn't had bottom washed b4 + groin area — put pullup on with inner pad — fatty cream on below knees — feet area — no broken skin — into bed lift legs up — Hearing aids out disconnect — into case in front

[15] Relevant dates are referred to as Days 1–3 to protect privacy.

> of TV — teeth clean. Jolly forgot. Urinary by bed on floor/walker able to reach. Has heater on."

34. RN C was on duty at the rest home between 11pm on Day 1 and 7am on Day 2. She observed Mr B several times during the night. She documented in the progress notes that each time she saw him, he was sleeping in his chair. She told HDC that she does not recall any other observations of Mr B during that night.

Morning visit by Mr F (Day 2)

35. On the morning of Day 2, Mr F, a friend, visited Mr B. Mr F told HDC that when he reached Mr B's room, Mr B was in the bathroom and called out to him. Mr B walked back from the bathroom to his bed, but had difficulty getting into his bed by himself, so Mr F assisted him.

36. Mr F told HDC that he recalls observing that Mr B looked pale and unwell, and that Mr B told him that he did not feel well. Mr F related these concerns to a member of staff who was working in the office, and she told him that she would look into it.

37. The rest-home company told HDC that neither RN C nor other staff have any recollection of Mr F visiting Mr B that morning. The rest home has no record of Mr F visiting Mr B, either in its visitors' book or elsewhere. I note that it was anticipated and recorded in Mr B's care plan that a visitor would attend between 10am and 10.30am on Wednesday mornings, and that Day 2 was a Wednesday.

Care provided (Day 2)

Staff on the premises

38. Ms E was on duty as a caregiver between 7am and 2pm on Day 2. The caregivers' position description required that caregivers:

> "Observe and report any changes in the resident's condition and vital signs. This includes appropriate upward reporting, sharing relevant information with colleagues and maintaining a good working relationship with management."

39. As noted above, RN C's shift finished at 7am on Day 2. However, she remained at the premises for several hours after her shift ended.

Morning observations

40. Ms E documented in the progress notes that Mr B had "appeared settled th[at] morning until 1145hs", but that at 11.45am, Mr B reported to her that he felt "abdominal soreness" and told her: "I can't move." Ms E further documented that Mr B may have been suffering the "onset of anxiety", and that he "refused to mobilise to [the] dining room" for lunch.

41. Ms E told HDC that Mr B said that he had "a slight upset tummy/stomach ache". She said that she told RN C "about Mr B and that he was reluctant to come down for lunch". However, she does "not recall any conversation with [RN C] about 'abdominal soreness and inability to move'", and said that if she had "had any concerns", she "would have

contacted [the registered nurse] for advice/instructions as the [registered nurse] would have expected this of [her]".

42. RN C told HDC that Ms E did not inform her that Mr B had reported abdominal soreness and immobility.

43. Ms E told HDC that RN C suggested that she push Mr B to the dining room in a wheelchair. Ms E documented in the progress notes that RN C "suggested wheelchair". RN C told HDC that she cannot recall advising Ms E to offer to push Mr B to the dining room in a wheelchair. RN C believes that she herself did not assess whether Mr B needed a wheelchair, but simply advised Ms E to try offering one. RN C stated that it was "not unusual for a new resident to be reluctant to go to the dining room initially".

44. Ms E documented in the progress notes that she "chaired [Mr B] to dining room". She told HDC: "[Mr B] appeared content to come down in a wheelchair to try and have something to eat and a drink."

Observations at lunch

45. Ms E documented in the progress notes that while Mr B was in the dining room for lunch, she observed his body "shaking", and noticed that he had "vomited mucus/phlegm". She documented that he "refused to eat lunch that had been served to him", but drank some fluids and "mobilised to [his] bedroom [with a] walker".

46. Ms E told HDC that "[t]here was no coughing noted from Mr B". However, Mr B did dribble "a small amount of orange juice coloured ??/phlegm". She told HDC that this phlegm was not dark in colour, and did not have a foul odour. RN C told HDC that Ms E did not inform her that she had observed Mr B exuding phlegm and shaking.

47. RN C believes that she left the premises between 12pm and 1pm, and told HDC that she does not recall reviewing Mr B before leaving.

48. RN C said that it was not "normal practice for the [registered nurse] in most facilities to sight each resident before going off duty", and she was not aware of any standard requiring registered nurses to do so. Similarly, the rest-home company submitted that industry practice does not require a registered nurse to review all residents for whom the nurse is responsible before the nurse's shift ends — only those residents who are unwell.[16]

49. RN C told HDC that had she been told about any other concerns regarding Mr B (other than his hesitation to go to the dining room, which she considered normal), she would have reviewed Mr B before she left the premises, and would have given specific instructions to Ms E before leaving the facility.

50. Ms E told HDC: "I checked on [Mr B] during the remainder of my duty. He appeared comfortable and rested on his bed." Ms E documented in the progress notes that Mr B was "resting in [his] chair".

[16] RN C and the rest-home company provided these submissions in response to expert advice received.

51. RN C told HDC that Ms E was a "very reliable and diligent care worker" whom she would have expected to immediately "report any concerns or signs that [Mr B] may not be well".

Handover to Ms I

52. Ms I was on duty as a caregiver between 2pm and 8pm; the beginning of her shift coincided with the end of Ms E's shift. Ms E told HDC that at the end of her shift (2pm), she told the caregiver who was taking over from her to contact the registered nurse if there were any further concerns. This handover conversation was not documented.

53. Ms I did not document any progress notes about Mr B during her time on duty.

54. The rest-home company told HDC that Ms I would have visited Mr B to offer him a cup of tea at about 2.30pm, when the rest home usually organises afternoon tea for its residents.

55. RN C told HDC that Ms I had "appropriate assessment skills to identify a clinical issue and act accordingly".

Telephone discussion with Mr B

56. Mrs A, Mr B's daughter, told HDC that at about 3.30pm on Day 2 her mother, Mrs B, called her to tell her that she was worried about Mr B. Mrs B told her daughter that she had telephoned Mr B and spoken with him briefly, and that during their discussion, Mr B "was not making any sense", and had "asked whether it was night or day [and] hung up". Mrs A said that Mrs B then telephoned the rest home and spoke to a member of staff. Following this discussion with her mother, Mrs A decided to visit her father.

Mrs A's visit to the rest home

57. Mrs A arrived at the rest home at about 4.30pm. She told HDC that she found her father "slumped in his chair with an ice-cream container at his feet that had dried blood and sputum in it. He was running a temperature, pale, sweaty and in rousing him he said he hurt." She also told HDC that "he was clearly unwell and in pain".

58. Mrs A told HDC that she "went straight to [Ms I] and said [she] wanted to call an ambulance", but Ms I "insisted [she] ring the Manager/Owner". Mrs A telephoned RN C, who at first told her to wait with Mr B while she (RN C) went to the rest home to assess him. Almost immediately after ending this call, RN C noticed that it was late in the day, and that the window of time in which Mr B's general practitioner could be contacted was closing. She telephoned Mrs A, and advised her to call Mr B's general practitioner (GP) to ask him to assess Mr B's health.

59. Mrs A told HDC that she spoke with the GP's nurse briefly at about 4.55pm, but was told that the GP would not be able to assess Mr B that day. Consequently, Mrs A called the ambulance.

60. The caregiver, Ms G, recorded in the progress notes:

> "4.30 — Daughter came in — had checked. Very uncooperative to pull pants up — daughter not happy Dad not good at all rang [RN C] — she talked daughter. Daughter

> rang 16.50 [medical centre] nurse said get ambulance — Ambo and self moved him onto wheelchair then out onto stretcher outside to Ambulance. Med charts/medical details copied went too with them."

Transfer to hospital

61. The ambulance staff reached the rest home at 5.06pm and transferred Mr B to the public hospital. The "Ambulance Care Summary" noted that at 5.13pm Mr B's heart rate was 89 beats per minute, his respiratory rate was 48 breaths per minute, his blood pressure was 189/90mmHg, his temperature was 38.7°C, and his oxygen saturation was 89%. At 5.40pm, his blood pressure had decreased to 168/64mmHg, and his oxygen saturation had increased to 97%. These were abnormal vital signs for a man of Mr B's age. The care summary also noted that the ambulance team's "primary clinical impression" of Mr B was "sepsis".

62. Mr B was seen by staff at the public hospital at around 6.30pm. His "Patient Transfer" form listed his presenting complaints as "confusion" and "fever". A chest X-ray was performed, and this showed lower left lung changes and an enlarged heart. At around 8.30pm, a CT scan showed both free fluid and free air in Mr B's abdomen, and that Mr B's small intestine had thickened, causing inversion of one part of the intestine within another. The radiologist speculated that this had caused small holes to appear in Mr B's intestine.

63. Following these diagnoses, medical staff, Mr B, and his family discussed the appropriate course of action. They decided that in light of Mr B's background co-morbidities (such as his metastatic melanoma), an emergency operation would not be appropriate for him, and palliative care was commenced.

64. Mr B passed away at 7.50pm on Day 3. His "Medical Certificate of Cause of Death" recorded "Abdominal sepsis and bowel perforation" as his direct cause of death, with "Metastatic melanoma" as the antecedent cause.

Further information — RN C

65. RN C told HDC that she was "not in a position to know whether [caregivers Ms E or Ms I] should have picked up that [Mr B] had become acutely unwell and that baseline observations should have been taken and [RN C] notified", and said that it was unclear to her "why or how [Mr B's] deterioration was not picked up earlier by the caregivers in this case".

Apologies and acknowledgements

66. RN C told HDC that she "has carefully considered her practice and responsibilities as a registered nurse since matters relating to the care provided to [Mr B] have been raised". She stated:

> "I unreservedly apologise for any lapses in the care provided to [Mr B], whether by me personally or by anyone working under my supervision. I am deeply sorry for the distress that [Mr B] may have experienced, and for any distress caused to his family."

67. RN C acknowledged that "there were inadequacies in her supervision of the enrolled nurse and care assistants who provided care to [Mr B] during the time that he was at [the rest home]". She accepts that as the registered nurse she had overall responsibility for Mr B's care. She also accepts that in this case, unfortunately the steps that she would normally have taken as part of her overall responsibility for Mr B's care, including co-signing the admission care plan and reviewing Mr B herself within 24 hours of admission, were not taken. She noted that this was "out of character" for her, and was "a one off departure" from her normal practice.

Changes to practice

68. RN C told HDC that since these events, she has "implemented an admission checklist to ensure everything is completed correctly". In relation to her own practice since these events, she has re-read the Nursing Council guidelines on "Responsibilities for direction and delegation of care to enrolled nurses" and "Delegation of care by a registered nurse to a health care assistant".

Further information — the rest-home company

Contract between the DHB and the rest-home company

69. The contract between the DHB and the rest-home company requires the rest-home company to provide short-term, residential facility, rest-home-level care at the rest home to people who have a main carer, and the contract requires the DHB to remunerate the rest-home company for that service. The associated service specification "Short-Term Residential Care Services For People in Contracted Residential Facilities Tier Level Two" requires the rest-home company to:

a) Provide for a registered nurse to "conduct an assessment [of the consumer] within 24 hours of admission".

b) "[U]se assessment information available from any current assessment (eg. interRAI HC …) to inform care planning and prevent duplication of assessment."

c) Document "baseline information regarding the Service User's health status, abilities and support needs".

Appropriate staffing

70. The rest-home company told HDC that the staff coverage at the rest home complies with Ministry of Health guidelines. Furthermore, it submitted that it is common in facilities of the rest home's size to employ only one registered nurse.

Apologies and acknowledgements

71. The rest-home company told HDC that it was "upset to discover that the level of care provided to [Mr B] was not as sufficient as it should have been". It acknowledged that Mr B's deteriorating condition should have been noticed earlier, and that the care it provided to Mr B was "below acceptable standards". The rest-home company further affirmed that its changes to practice will ensure that this does not happen again.

Changes to practice

72. The rest-home company told HDC:

a) When new residents are admitted, it is now usual practice to access that resident's interRAI assessment.

b) It has implemented a new handover procedure, whereby at the three handover times of 7am, 2pm, and 11pm, both on-coming and off-going staff physically sight each resident. Previously, this procedure occurred only at 11pm.

c) RN C is now responsible for all admissions. When she is not able to admit a new resident, another registered nurse is contracted to do this.

d) It now "ensures that all important details are fully documented and a resident's full medical overview can be obtained after staff have left".

e) It has entered all of its Level 4 caregivers into a programme with the NZ Tertiary College to upskill their level of competency.

f) "Documentation practices at [the rest home] [in 2019] are much more robust than they were in 2016."

g) Its caregivers now receive annual training on the HDC Code of Rights, and its caregivers "now have a greater awareness of the need to closely monitor residents and report to the registered nurse if they have any concerns".

The rest home's policies

73. At the time of these events, the rest home had "Guidelines for Illness Assessment". These stated that "[i]f a resident [was] found to be unwell or complaining of feeling unwell", staff should "[a]sk for details of [the] illness and document", "[t]ake temp, pulse, BP and record on the appropriate chart", "[n]otify [the] RN", "[p]lace the resident on their bed and observe ½ hourly for changes in condition", and thereafter monitor the resident.

Responses to provisional opinion

74. Mr B's family were given an opportunity to respond to the "Information gathered" section of the provisional opinion. Their responses have been incorporated into the report where appropriate. Mrs B told HDC that she was concerned about "the lack of communications amongst the staff", and "frankly appalled" that the rest home "lacked any cohesion". She stated: "It took my daughter to arrive to get the care [Mr B] deserved. I feel heartsick he had to suffer that prior to the day he died."

75. Mrs A told HDC that she noted the staff's explanation that they assumed Mr B was reluctant to go to lunch because of anxiety, but found this explanation "dismissive and weak". She stated that she visited her father at dinner on Day 1, and that "he was in the dining room eating dinner and had no anxiety at all".

76. Mrs A also stated that when she arrived at the rest home on Day 2, Mr B's door was closed. She said:

> "It concerns me for all the indications of him being unwell through the day (his comments, [Mr F], Mum) that they maintained no visibility of him as he was behind a closed door."

77. The rest-home company and RN C were given an opportunity to respond to relevant sections of the provisional opinion.

78. The rest-home company told HDC that it accepts the Deputy Commissioner's findings. The rest-home company also showed the relevant parts of the provisional opinion to Ms E and Ms G, and they did not wish to make any comments.

79. RN C told HDC that she accepts the Deputy Commissioner's findings.

Relevant standards

80. The Nursing Council of New Zealand *Code of Conduct for Nurses* requires registered nurses to "[u]se appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care".[17]

81. The *Code of Conduct* states:

> "When you delegate nursing activities to enrolled nurses or others ensure they have the appropriate knowledge and skills, and know when to report findings and ask for assistance."[18]

82. The Nursing Council of New Zealand "Guideline: responsibilities for direction and delegation of care to enrolled nurses" states:

a) "Enrolled nurses are legally required to work under the direction of a delegation of a registered nurse or in some settings this may be another registered health practitioner."[19]

b) Although "[e]nrolled nurses contribute to nursing assessments, care planning, implementation and evaluation of care for health consumers and/or families/ whānau", the "registered nurse maintains overall responsibility for the plan of care".[20]

c) "The registered nurse must ensure the enrolled nurse understands the nursing interventions required, and knows when to ask for assistance and when to report back to the registered nurse."[21]

[17] Nursing Council of New Zealand, *Code of Conduct for Nurses* (June 2012), Standard 4.1, p 20.
[18] Ibid, Standard 6.8, p 29.
[19] Nursing Council of New Zealand, "Guideline: responsibilities for direction and delegation of care to enrolled nurses" (May 2011), Introduction, p 4.
[20] Ibid, Enrolled nurse scope of practice, p 6.

d) "The health consumer must have a plan of care developed by a registered nurse. This may be developed in collaboration with the enrolled nurse."[22]

e) "The registered nurse must provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible."[23]

83. The Nursing Council of New Zealand "Guideline: delegation of care by a registered nurse to a health care assistant" states:

a) "The health consumer must have a plan of care developed by a registered nurse who has undertaken a comprehensive assessment."[24]

b) "The registered nurse must provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible. This must be planned along with the necessary support and guidance that will be provided to the health care assistant performing the delegated activity."[25]

c) "The registered nurse must be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation."[26]

d) "The registered nurse retains accountability for evaluation whether the health care assistant carrying out the delegated activities maintains the relevant standards and outcomes."[27]

Opinion: Rest-home company — breach

Standard of care provided — breach

84. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), the rest-home company had a duty to provide its residents with services of an appropriate standard. The New Zealand Health and Disability Service Standards require organisations (including rest homes) to ensure that their services are managed in an efficient and effective manner, to ensure the provision of timely and safe services to consumers.[28]

[21] Ibid, The principles of delegation to enrolled nurses, Principle 3, p 8.
[22] Ibid, The responsibilities of the registered nurse, Responsibility (a), p 8.
[23] Ibid, Responsibility (c), p 8.
[24] Nursing Council of New Zealand, "Guideline: delegation of care by a registered nurse to a health care assistant" (May 2011), "The responsibilities of the registered nurse", Responsibility 1(a), p 6.
[25] Ibid, Responsibility 1(c), p 6.
[26] Ibid, Responsibility 1(d), p 6.
[27] Ibid, Responsibility 3(a), p 7.
[28] NZS 8134.1.2:2008 at 2.2.

85. Mr B required rest-home-level care for respite to give his wife some relief as his main caregiver. He was not known to the rest home on his admission. In such circumstances, rest-home staff need to promptly gain a comprehensive understanding of the individual's medical history, their health status on admission, and the nature of support they are likely to require, and then be alert to any changes. This case highlights the importance of aged-care facilities ensuring that all new admissions are assessed by suitably skilled clinical staff in a timely manner, to identify and then record the nature of support the person will require to meet their needs and keep them safe. The events described in this report highlight how susceptible residents in aged-care facilities are to a rapid deterioration in their condition. Both clinical and support staff need to think critically about a resident's presenting symptoms, and provide appropriate intervention, including escalating concerns and seeking medical intervention as warranted. In my view, the rest-home company failed in its duty to provide an appropriate standard of care to Mr B.

Admission and care planning

86. The "Resident Admission" policy stated that a new resident's assessment on admission would "utilise information gained from the resident, the nominated representative, and that provided by the referring agency".

87. At the time of Mr B's admission, RN C incorrectly believed that only registered nurses could access the interRAI tool, so it was not the rest-home company's practice for enrolled nurses to access the interRAI when performing an initial assessment upon admission. Since Mr B's initial assessment was performed by an enrolled nurse — EN D — rather than a registered nurse, it followed that the information from Mr B's interRAI assessment did not inform the rest home's initial assessment or care planning.

88. The "Recordings" policy required a staff member to take base recordings of new residents on admission, and to document these recordings.

89. There is no documentation to show that a staff member took Mr B's base recordings on admission. RN C acknowledged this, and said that the failure to document base recordings was a breach of the rest home's policy. My expert advisor, RN Lilly, said that she would "consider it good practice to take baseline recordings for all residents, permanent or respite as this provides a benchmark in case of deterioration". I accept this advice. Mr B's baseline recordings were pertinent information that could have assisted staff to evaluate subsequent changes to Mr B's health.

90. The "Care Plans" policy provides that "[o]n admission a nursing assessment is undertaken by a suitably qualified registered nurse".

91. Mr B's admission was facilitated by an enrolled nurse — EN D — rather than by a registered nurse. Furthermore, there is no documentation showing that RN C assessed Mr B herself, or discussed Mr B's care plan with EN D and reviewed the care plan that EN D had prepared.

92. RN C told HDC that her normal practice was to either "create the care plan herself" or to delegate that duty to an enrolled nurse and then "co-sign the plan within 24 hours". She

said that it would have been her intention to complete this on her next duty on the night of Day 2. She stated that she was "unable to recall why, on this occasion, [she] didn't co-sign the plan".

93. RN Lilly advised:

> "It is standard practice to have an RN co-sign an assessment done by an enrolled nurse. On this occasion the co-signing was not done. [RN C] states in her response that it was normal practice to co-sign the care plans. If this is the case then I consider it a minor departure from accepted practice. I also note that [RN C] has reflected on the omission and has implemented a corrective action around it."

94. I accept this advice. The rest-home company needed to ensure that Mr B's care plan was either completed or reviewed by a registered nurse on admission, or promptly after admission. I note that RN C was the nurse on duty between 11pm on Day 1 and 7am on Day 2. There was an opportunity during that time for RN C to review and sign Mr B's care plan.

95. I am critical of these departures from the rest home's policy during Mr B's admission. I note that the omission to incorporate information from the interRAI, and the omission to document Mr B's base recordings, meant that staff did not have all the relevant information about Mr B's health status to fully determine the nature of support he required or evaluate any changes in his condition.

Failure to respond to deterioration appropriately

96. The rest home's position description for its caregivers required them to "[o]bserve and report any changes in the resident's condition and vital signs", including "appropriate upward reporting". Furthermore, the "Guidelines for Illness Assessment" state that "[i]f a resident is found to be unwell or complaining of feeling unwell", then staff should notify the registered nurse and take the resident's pulse, temperature, and blood pressure.

97. Ms E, a caregiver, was on duty between 7am and 2pm on Day 2. At 11.45am on Day 2, Mr B told Ms E that he felt "abdominal soreness", that he could not move, and that he would not "mobilise to [the] dining room" for lunch. Ms E consulted RN C, but did not tell her that Mr B had reported pain. Instead, the discussion was related to Mr B's reluctance to attend lunch, and RN C gave advice about mobilising Mr B to the dining room.

98. While Mr B was at lunch, Ms E observed that at one point he was "shaking", and at another point that he vomited up a "small amount of orange juice coloured phlegm". Mr B did not eat lunch, but did drink some fluids and mobilise back to his bedroom without assistance. Following Mr B's return to his bedroom, there are no records of any observations of Mr B until 4.30pm, when Ms G documented that Mr B's daughter, Mrs A, had raised concerns about Mr B's well-being.

99. RN Lilly is critical that no recordings of vital signs were completed when Mr B became unwell, and she considers this to have been a "moderate departure from accepted

standards". She stated: "It would have been accepted practice to report even if there were no further issues."

100. RN Lilly advised:

> "In an aged care environment caregivers are predominantly the eyes and ears on the floor and have an expectation of having the awareness and reporting skills to report to their RN with any concerns. … The failure of caregivers to continue to monitor [Mr B] after being unwell and not reporting their concerns to the RN, my peers and I would consider the level of care was a moderate to serious departure from standard practices."

101. I agree with RN Lilly. Mr B was a new resident with complex health needs, and staff had not had an opportunity to become familiar with his health status and care needs. Furthermore, both the caregivers' job description and rest home policies required caregivers to respond appropriately to signs of unwellness in a resident, including alerting the registered nurse and taking the resident's vital signs. I am highly critical that Mr B's self-reports of soreness and immobility were not recognised as signs of possible unwellness, and that his care was not escalated to RN C and his vital signs taken to monitor any further deterioration.

102. There is considerable evidence that Mr B's condition was deteriorating on Day 2 prior to Mrs A's visit to the rest home. Mr F told HDC that when he visited Mr B in the morning of Day 2 (likely during the scheduled timeframe between 10am and 10.30am) he found Mr B to be pale and unwell, and that Mr B told him he did not feel well. Mrs A told HDC that when she saw her father at 4.30pm she observed him to be "clearly unwell and in pain". The "Ambulance Care Summary" recorded Mr B's heart rate as 89 beats per minute, his respiratory rate as 48 breaths per minute, his temperature as 38.7°C, and his oxygen saturation as 89% — these were abnormal results.

103. However, it appears that staff were not aware of Mr B's deterioration until Mrs A drew it to their attention. Rest-home staff need to be alert to signs of deterioration in a resident; it is unacceptable that Mr B's deterioration went unrecognised and unreported by staff until Mrs A's intervention.

104. I am critical that staff departed from the requirements in the policy for monitoring and observing patients. The lack of monitoring and escalation on Day 2 meant that staff failed to recognise Mr B's actual condition, particularly in respect of his deterioration through the afternoon, and there was a missed opportunity for Mr B to be assessed by a registered nurse.

Conclusion

105. In my view, the rest-home company had the ultimate responsibility to ensure that Mr B received care that was of an appropriate standard and complied with the Code. I am concerned that aspects of the care provided to Mr B were inadequate, and that there was a pattern of poor care. In particular:

- Staff did not obtain Mr B's interRAI information to inform his care plan.
- Staff did not take Mr B's baseline recordings at his admission.
- There was no documented review of Mr B's care plan (which had been prepared by an enrolled nurse) by a registered nurse.
- When Mr B complained of feeling unwell on Day 2, staff did not report this to a registered nurse or take Mr B's vital signs.

106. Accordingly, I find that the rest-home company did not provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code.[29]

Staffing levels — other comment

107. At the time of these events, RN C was the sole registered nurse at the rest home. Under Nursing Council guidelines, registered nurses who have delegated the care of consumers to enrolled nurses or caregivers remain responsible for providing "ongoing monitoring of the health status" of those consumers.[30] Consequently, RN C was responsible for the ongoing monitoring of the health status of all the rest-home residents (numbering up to 16 at any one time) 24 hours per day, seven days per week.

108. RN Lilly advised:

> "The governing body of [the rest home] should consider reviewing its staffing around Registered Nurses. Although it can be a financial burden for small facilities to have a back up RN, it is important that senior staff do not get fatigued. Of note, the roster has [RN C] doing four night shifts, and if this is the primary clinical manager, my colleagues and I do not consider this good practice."

109. RN Lilly also advised: "The RN, having just completed a full night shift and then staying on for a further five to six hours would not have helped decision making."

110. The rest-home company told HDC that the staff coverage at the rest home complies with Ministry of Health guidelines, and that it is common in facilities of its size to employ only one registered nurse. Corroborating this, the rest home was audited in 2015 and 2017, and both audit reports express approval of the rest home's staffing levels.

111. Nonetheless, I have noted the implications of RN C being the sole registered nurse at the rest home — for example, her staying at the premises for five to six hours after completing a full night shift. Accordingly, I strongly advise the rest-home company to consider RN Lilly's comments.

[29] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[30] Nursing Council of New Zealand, "Guideline: responsibilities for direction and delegation of care to enrolled nurses" (May 2011), The responsibilities of the registered nurse, Responsibility (c), p 8; Nursing Council of New Zealand, "Guideline: delegation of care by a registered nurse to a health care assistant" (May 2011), The responsibilities of the registered nurse, Responsibility 1(c), p 6.

Opinion: RN C — adverse comment

Introduction

112. RN C's Clinical Manager position description required her to "ensure that safe professional Nursing care [was] delivered" at the rest home, and to "effectively manage the facility as a quality continuing care environment". Furthermore, as the rest home's only registered nurse, Nursing Council guidelines required her to oversee, and be involved in, the healthcare services provided by the rest home's enrolled nurses and caregivers.

Admission of Mr B

113. EN D, an enrolled nurse, facilitated Mr B's admission to the rest home on Day 1. She conducted an initial assessment of his health and needs, and prepared a care plan for him.

114. The "Care Plans" policy required a registered nurse to assess new residents on admission; this policy reflects Nursing Council guidelines, which allow enrolled nurses to collaborate in the development of residents' care plans, but require those care plans to be developed by a registered nurse.[31]

115. Although RN C told HDC that she is "sure that she read and reviewed the care plan for [Mr B]", there is no documentation that she did so; in particular, she did not co-sign Mr B's care plan.

116. RN Lilly advised:

> "It is standard practice to have an RN co-sign an assessment done by an enrolled nurse. On this occasion the co-signing was not done. [RN C] states in her response that it was normal practice to co-sign the care plans. If this is the case then I consider it a minor departure from accepted practice. I also note that [RN C] has reflected on the omission and has implemented a corrective action around it. I would also consider it good practice to take baseline recordings for all residents, permanent or respite as this provides a benchmark in case of deterioration."

117. I accept this advice. I note that RN C stated that it is her usual practice to co-sign a new resident's care plan within 24 hours of admission, and that "it would have been her intention to complete this on her next duty on the night of [Day 2]". As the registered nurse responsible for Mr B, she was responsible for confirming Mr B's care plan, and I am critical of her for failing to do so.

Nursing oversight

118. RN C visited Mr B several times during the night of Day 1. She documented that on each visit she observed Mr B to be sleeping in his chair. I am critical of RN C's monitoring of Mr B. He was a new resident with significant medical conditions, and a more systematic assessment of him overnight would have been appropriate.

[31] Nursing Council of New Zealand, "Guideline: responsibilities for direction and delegation of care to enrolled nurses" (May 2011), "The responsibilities of the registered nurse", Responsibility (a), p 8.

119. On the morning of Day 2, Mr B told Ms E that he felt "abdominal soreness", that he could not move, and that he would not "mobilise to [the] dining room" for lunch. However, Ms E reported to RN C (her supervisor) only that Mr B was reluctant to attend the dining room for lunch. Later that day, Ms E observed Mr B "shaking" and vomiting a "small amount of orange juice coloured phlegm". However, she did not report these observations to RN C, as she believed that otherwise Mr B appeared to be well.

120. RN C submitted that it was "not unusual for a new resident to be reluctant to go to the dining room initially".

121. RN C left the premises between 12pm and 1pm without having reviewed Mr B.

122. RN Lilly advised:

> "[RN C] relied on her caregivers to follow [rest-home] policies and procedures, and this may have led to identifying [Mr B's] deteriorating condition sooner had they done this. It is therefore difficult to hold [RN C] fully responsible for the outcome, however, as a sole charge RN in a small facility I would consider it good practice to review new residents before leaving the premises. Duty of care is the final responsibility of the RN."

123. RN C submitted that it was not "normal practice for the [registered nurse] in most facilities to sight each resident before going off duty", and that she was not aware of any standard requiring registered nurses to do so. The rest-home company emphasised to HDC that had RN C "been aware of any concerns regarding [Mr B], she would have reviewed [Mr B] before ending her shift".

124. In determining this issue, I have considered the following:

a) The "Pain Management" policy and "Progress Notes Writing Guidelines" specified that caregivers must document residents' expressions of pain for the registered nurse to follow up, while the "Client Progress Notes" policy stated that the registered nurse is to follow up residents' documentation.

b) The Nursing Council guidelines on delegation required registered nurses to "provide ongoing monitoring of the health status of the health consumers for whom [they are] responsible",[32] and to "be directly involved with the health consumer" where that consumer's responses are "less predictable or changing".[33]

125. In my opinion, the rest home's policies and the Nursing Council guidelines placed an obligation on the registered nurse to be proactive about monitoring residents' health rather than being too dependent on caregivers' reports. It was especially important that the registered nurse be proactive in Mr B's case, because staff were yet to become familiar

[32] Nursing Council of New Zealand, "Guideline: delegation of care by a registered nurse to a health care assistant" (May 2011), "The responsibilities of the registered nurse", Responsibility 1(c), p 6.
[33] Ibid, Responsibility 1(d), p 6.

with his normal health and behaviours (meaning that they would be less likely to recognise clinical deterioration), and because of his complex health needs.

126. As the Clinical Manager and sole registered nurse, RN C was required to provide nursing care and interventions to the residents. She also remained responsible for supervising the caregivers and the care they provided to residents. Therefore, although I acknowledge the lack of escalation of Mr B's unwellness to RN C, I agree with RN Lilly that it would have been good practice for RN C to review Mr B — a new resident admitted the previous day for respite care — before leaving the premises. The failure to do this was a missed opportunity for a clinical review of Mr B, and I am critical that this did not occur.

Recommendations

127. I recommend that the rest-home company:

a) Prepare a written apology to Mr B's family. The apology is to be provided to HDC, for forwarding to Mr B's family, within three weeks of the date of this report.

b) Confirm to HDC that it has implemented the changes to practice noted at paragraph 72 of this report, and the effectiveness of those changes, within three months of the date of this report.

c) Review its current policies and procedures relating to the assessment, management, and monitoring of pain, and report to HDC on any proposed changes that it implements in this respect, within three months of the date of this report.

d) Review the orientation training it provides to staff on documentation, and consider whether the training needs to be revised, and report to HDC on the outcome of its review and consideration within three months of the date of this report.

e) Review the education it provides to its caregivers on the subjects of illness assessment and clear communication to senior staff, and report to HDC on the outcome of its review within three months of the date of this report.

f) Consider whether it needs to employ or contract additional registered nurses to meet its obligations to residents confidently, and report to HDC on the outcome of its consideration within three months of the date of this report.

128. I recommend that RN C:

a) Prepare a written apology to Mr B's family. The apology is to be provided to HDC, for forwarding to Mr B's family, within three weeks of the date of this report.

b) Undertake further education and training on the subject of delegating responsibility to enrolled nurses and caregivers, and report to HDC on her learning from the education and training, within six months of the date of this report.

Follow-up actions

129. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to HealthCERT and the District Health Board, and they will be advised of the rest-home company's and the rest home's names.

130. A copy of this report with details identifying the parties removed, except 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.

131. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Nurses Organisation and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Sheryl Lilly on 6 February 2019:

"**1.Disclaimer**

I, Sheryl Lilly, have been asked to provide an opinion to the Commissioner on case number C18HDC00217 and I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I have no known personal or professional conflict in this case.

2. Expert's Background

I have been a New Zealand Registered nurse for Thirty years with a background in clinical care and aged care nursing management. I am an owner/operator of a 20 bed rest home for the past ten years and also own another 28 bed facility, that I purchased 5 years ago. I am also a Career Force assessor.

3. Instructions from the Commissioner

I have been asked to review the documentation sent to me and advise whether I consider the care provided to [Mr B] at [the rest home] was reasonable in the circumstances, and why.

In particular please comment on:

1. Assessment and Monitoring of [Mr B's] condition
2. Whether multidisciplinary review should have been sought
3. The adequacy of [the rest home's] documentation
4. The adequacy of [the rest home's] relevant policies
5. Any other matters in this case that you consider warrant comment.

4. Sources of Information

Supplied by the HDC office:

- Letter of complaint dated […]
- [The rest home's] response dated 20 February 2018
- Clinical records from [the rest home] for [Days 1–3]
- Ambulance care summary from [the ambulance service]
- Comment and clinical records from [the DHB] for [Days 1–3]
- [The rest home's] response including statements and clinical information dated 30 October 2018
- Response from [RN C] dated 15 October 2018

5. Factual summary

[Mr B] was admitted to [the rest home] for two weeks of respite care. His family are concerned that his declining condition was not adequately monitored or escalated to other health care providers. [Mr B] was admitted to [hospital] and found to be severely dehydrated, with a perforated bowel.

6. Expert Review

6.1 *Assessment and monitoring of [Mr B's] condition and Whether Multi-disciplinary review should have been sought*

It is a requirement on admission to do a full assessment of a resident[1], and this should cover all facets of that new resident using appropriate resources such as GP notes, family members and the resident themselves.

There is evidence of an assessment done in a timely manner, which identified relevant clinical issues including a lung melanoma that was reported by the family member to be in remission, diabetes that was not actively treated, a lump on his neck and frequency of urination. Other appropriate information was also recorded around pain, respiratory, nutrition, and general needs. I note that baseline recordings were not done and [RN C] stated that they normally are not done for respite residents. From this information a Short term care plan was documented.

This documentation has met accepted practice; however, it was an Enrolled nurse who carried out the assessment, and it is a requirement under Nursing Council guidelines2 that enrolled nurses come under the direction and delegation of a registered nurse. It is standard practice to have an RN co-sign an assessment done by an enrolled nurse. On this occasion the co-signing was not done. [RN C] states in her response3 that it was normal practice to co-sign the careplans. If this is the case then I consider it a minor departure from accepted practice. I also note that [RN C] has reflected on the omission and has implemented a corrective action around it.4 I would also consider it good practice to take baseline recordings for all residents, permanent or respite as this provides a benchmark in case of deterioration.

[Mr B] complained of "abdominal soreness"5 with onset of shaking and stating "I can't move". This was reported to [RN C] who suggested bringing him to Lunch in a wheelchair, where he refused lunch, vomited phlegm, had some fluids and mobilised back to his room.

It would have been best practice, for the RN to review [Mr B] at that time, having been told by the caregiver that he was not feeling well. He was a new resident not known by staff, and had indicated pain. This may or may not have led to an immediate

[1] HDSS 1.3.4
[2] www.nursingcouncil.org.nz
[3] Lawyer dated 23 July 2018
[4] Lawyer dated 23 July 2018
[5] Progress notes dated [Day 2]

review by other multidisciplinary team members, such as [Mr B's] GP; this would have depended on the RN assessment.

There is no written evidence of a further review of [Mr B] that afternoon by the RN, [RN C] or any caregivers. The RN states[6] that she did not review [Mr B] as [Ms E] the caregiver did not report any further concerns to her. There is no further reporting on [Mr B] until his daughter raised her concerns at 1630 hrs that same afternoon.

In the aged care environment caregivers are predominantly the eyes and ears on the floor and have an expectation of having the awareness and reporting skills to report to their RN with any concerns. There is evidence of documentation around guidelines for illness assessment for caregivers to refer to which states the procedure to follow including taking baseline recordings, noting changes in behaviour, breathing and colour and Reporting to the RN. However this does not negate the duties of an RN.

[RN C] was on duty until lunch time and then left as she had been on night duty.

Registered Nurses have a duty to provide safe and appropriate care.[7] I am critical of the lack of monitoring of [Mr B]. [The rest home] has a Pain Management policy in place[8] and this clearly states pain should be taken seriously, recordings should be taken and followed up by the RN. There is no documentation supporting that this procedure was carried out and [RN C] states she did not sight [Mr B].[9]

I consider there has been both a clinical and systems failure, and [the rest home] was in breach of their policies around pain management and illness assessment. Although [RN C] had left to go home, being the RN in charge, there is an expectation that she would first review residents and leave instructions for the staff left on the floor,[10] and this would have included monitoring [Mr B's] un-wellness.

Taking into account [RN C's] response[11] around reflecting on the event, responding with an improvement on her role as an RN, and improving documentation. The failure of caregivers to continue to monitor [Mr B] after being unwell and not reporting their concerns to the RN, my peers and I would consider the level of care was a moderate to serious departure from standard practices.

The fact that the RN did not review [Mr B] and consider further review by his GP before going off duty is a departure from accepted practice. If the RN was not told of concerns by the caregivers then I would consider this a moderate departure; however, if the RN overlooked her duty of care by not reviewing [Mr B] when knowing he was unwell then I would consider this a serious departure from expected care.

The governing body of [the rest home] should consider reviewing its staffing around Registered Nurses. Although it can be a financial burden for small facilities to have a

[6] Section 9 Lawyers document dated 23 July 2018
[7] Nursing Council Code of Conduct
[8] Pain Management issued 13/4/15, reviewed Feb. 2016
[9] Lawyers document dated 23 July 2018
[10] Nursing Council, direction and delegation.
[11] Section 9 Lawyers document dated 23 July 2018

back up RN, it is important that senior staff do not get fatigued. Of note, the roster[12] has [RN C] doing four night shifts, and if this is the primary clinical manager, my colleagues and I do not consider this good practice.

The RN, having just completed a full night shift and then staying on for a further five to six hours would not have helped decision making around residents' wellbeing. Direction and Delegation is a skill that requires robust policies and good staff that clearly understand their observation and reporting roles.

I would recommend reviewing caregivers' education around Illness Assessment and Monitoring, and the importance of clear communication to senior staff.

6.2 *The adequacy of [the rest home's] documentation*

There is evidence of admission documentation completed that meets accepted standards.[13] This includes Initial Assessment on Admission, Coombes Assessment for predicting fall risk, and a continence Assessment. A Short Term Care Plan was also completed; however as previously noted this was completed by an Enrolled nurse and should have been co-signed by the RN.

The progress notes are dated, signed with, in most cases, a designation. The shift is also noted; however, it is best practice to write the time of writing the report instead of just the duty.

I am critical of the fact that no recordings of vital signs were completed or documented when [Mr B] became unwell, nor was there any further documentation around checking [Mr B] through the afternoon. It would have been accepted practice to report even if there were no further issues. The lack of documentation on [Day 2] is in clear breach of their policies[14] and below accepted practice. My peers and I consider this a moderate departure from accepted Standards.

There is evidence of policies and guidelines [15] around documentation. However there is no evidence of reviewing these during orientation or staff training. I would recommend a change in the orientation policy to include documentation skills and that they be included in staff training.

6.3 *The adequacy of [the rest home's] relevant policies*

I have been provided with the following policies: Admission, Assessment, Progress notes, Open disclosure, Emergency, Orientation, Pain Management, Care plans and respite care.

These policies meet the current standards as evidenced by their last audit.[16]

[12] Roster, Week 1
[13] HDSS 1.3.4
[14] Guidelines for illness assessment, progress notes policy.
[15] Rest home Client progress notes policy and progress notes writing guidelines.
[16] MOH certification Audit June 2018

However, there has been a failure to follow some of those policies. As previously discussed above, I recommend further education of the staff around responsibilities of observation, reporting, and correct documentation.

Sheryl Lilly"

The following expert advice was obtained from RN Lilly on 20 May 2019:

"Thank you for giving me the opportunity to review my report and respond accordingly.

Having reviewed the response letters completed by [RN C's lawyer], the information has given me further clarification of the incident from [RN C's] point of view.

Please accept the changes referring to my original advice.

6.1 Assessment and monitoring of [Mr B's] condition and whether multi-disciplinary review should have been sought.

In the clinical notes dated [Day 2] [Ms E] wrote: 'onset of shaking noted, abdominal soreness', 'I can't move', 'appears to have onset of anxiety? Refused to mobilise to dining room. Rn aware of same.'

[RN C's lawyer's] report Paragraph 5c states [Ms E] simply told [RN C] that [Mr B] was reluctant to go to the dining room.

My initial opinion was in response to the documentation available to me, leading to my understanding that [RN C] was aware of [Mr B's] presentation at lunch time.

Considering that [RN C] states she was not told of [Mr B's] symptoms, only his reluctance to go to the dining room and this is confirmed by [Ms E], my original opinion has changed.

[RN C] states in her response[17] that she places trust in her caregivers to report any concerns to her as per [rest-home] policy. [RN C] also states that she would have checked on [Mr B] had there been any concerns raised.

[RN C] relied on her caregivers to follow [rest-home] policies and procedures, and this may have led to identifying [Mr B's] deteriorating condition sooner had they done this. It is therefore difficult to hold [RN C] fully responsible for the outcome; however, as a sole charge RN in a small facility I would consider it good practice to review new residents before leaving the premises. Duty of care is the final responsibility of the RN. I consider there has been a moderate departure from standard practice of care.

6.2 and 6.3

My considerations are unchanged.

Kind Regards, **Sheryl Lilly RN**"

[17] Paragraph 9,10,11