Heritage Lifecare Limited
Clinical Services Manager, RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC00700)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man by Heritage Lifecare Limited and the clinical services manager during the man's admission for palliative care. The report highlights the need to ensure that a resident's palliative care is planned appropriately to meet the person's end-of-life care needs.

2. The man required hospital-level care and was admitted to a rest home with wounds on his legs. His wound dressings were changed infrequently, he reported pain during dressing changes, and he experienced three falls. During his residency he became increasingly unwell. He lost weight and this was not monitored by staff. He was not offered regular showers, his room was found to be dirty, and maggots were found on his toes. There were delays in arranging reviews by a GP and a podiatrist. In the man's final days at the rest home, the family raised concerns that his condition had deteriorated, and made a formal complaint, but there was no review or adequate response by senior staff.

Findings

3. The Deputy Commissioner found Heritage Lifecare Limited in breach of Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code). The number of failings by Heritage Lifecare Limited and its staff pointed towards an environment that did not assist staff sufficiently to do what was required of them. Basic care the man should have received was lacking.

4. The Deputy Commissioner also found the clinical services manager in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that she did not provide appropriate oversight of the nursing documentation and care planning, and was concerned that she did not comply with the complaints policy.

Recommendations

5. The Deputy Commissioner recommended that the Nursing Council of New Zealand carry out a competence review of the clinical services manager, and that she apologise to the family.

6. The Deputy Commissioner recommended that Heritage Lifecare Limited report back to HDC on its Corrective Action Plan; conduct an audit of its compliance with its protocols for registered nurses reporting changes in a resident's condition to senior staff; review its palliative care policies; use this report as a basis for staff training; use the learnings and insights from the man's experience and disseminate this opinion more widely among Heritage Lifecare Limited's care homes; and provide a formal written apology to the family.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided at the rest home to her father, the late Mr A. The following issues were identified for investigation:

- *Whether Heritage Lifecare Limited provided Mr A with an appropriate standard of care during the period Month1[1] to Month4 (inclusive).*
- *Whether Registered Nurse (RN) C provided Mr A with an appropriate standard of care during the period Month1 to Month4 (inclusive).*

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

9. The parties directly involved in the investigation were:

Ms B	Consumer's daughter/complainant
Heritage Lifecare Limited	Provider
RN C	Provider/clinical services manager

10. Further information was received from:

RN D	Registered nurse
The Nursing Council of New Zealand	
The District Health Board (DHB)	

11. Also mentioned in this report:

Dr E	General practitioner (GP)

12. Independent expert advice was obtained from Registered Nurse (RN) Sheryl Lilly, and is included as **Appendix A.**

Information gathered during investigation

Mr A

13. Mr A, aged 86 years at the time of events, had a history of heart failure, atrial fibrillation,[2] gout,[3] chronic kidney disease, dementia, and a left lower leg wound. Mr A required one-person assistance for personal cares. He required supervision for toileting and mobilising

[1] Relevant months are referred to as Months 1–4 to protect privacy.
[2] An irregular, rapid heartbeat.
[3] A form of inflammatory arthritis.

with a walking frame. Mr A's daughter, Ms B, held an activated enduring power of attorney for personal care and welfare for Mr A.

14. Mr A was admitted to a public hospital owing to shortness of breath and oedema[4] in his lower legs. During his admission he was diagnosed with end-stage biventricular heart failure,[5] with a secondary diagnosis of aspiration pneumonia[6] and delirium on a background of dementia.[7] Mr A's family were advised that he was unresponsive to several treatment options, and it was agreed to proceed with full comfort cares.

15. On 5 Month1, Mr A was discharged from the public hospital and admitted to hospital-level care at the rest home for palliative care. The nursing summary states that Mr A had wounds on his legs that required regular wound dressings, and that he required the assistance of one person for his personal cares. The dietician summary states that a GP should continue to monitor Mr A's weight and nutritional status.

Rest home

16. The rest home provides rest-home and hospital-level services for people who have long-term chronic health conditions and/or require respite care. It is owned and operated by Heritage Lifecare Limited. The rest home is contracted by the DHB to provide rest-home and hospital-level care to consumers in the region.

17. At the time of events, two registered nurses were responsible for the monitoring of 60 residents in hospital-level care, including reporting any changes or concerns to the clinical services manager.

Clinical services manager

18. RN C was employed by the rest home as the clinical services manager, and was responsible for the management of the rest-home and hospital-level care. RN C stated that a senior registered nurse was employed to assist her with the management of the rest-home and hospital-level care areas.

19. RN C's employment agreement sets out the expectation of the clinical services manager's position. Under the heading "Key Accountabilities" it records:

> "
> - Provides leadership, supervision and direction to staff with active and applied knowledge and practice as per HPCA Act.[8]
> - Monitors the provision of care to residents to ensure the highest standards are achieved and maintained.
> - Provides oversight of resident clinical records and recordings to ensure they meet organisational and legislative requirements.

[4] Fluid retention.
[5] Both sides of the heart are affected.
[6] Lung infection caused by breathing in foreign material (eg, food, saliva, stomach acid).
[7] A gradual loss of brain function due to physical changes in the structure of the brain.
[8] Health Practitioners Competence Assurance Act 2003.

- Demonstrates commitment to the provision of a safe environment for residents and staff."

20. The clinical services manager is required to assist and support the facility manager in the effective management of the facility. The clinical services manager is also required to ensure that staff deliver clinical services in accordance with the rest home's policies and procedures. The position description sets out other tasks such as formal oversight of all care processes, training of registered nurses, and oversight of staff care and clinical skills.

21. The rest home said that the clinical services manager is responsible for random checks and internal audits of all plans of care, including wound plans, to ensure accurate reporting and that evaluations are taking place in a timely manner.

22. RN C told HDC that she had had no previous experience as a clinical services manager in a residential care setting. She said that her orientation included three half days of in-house training, a two-hour meeting with the facility manager, and attendance at an InterRAI assessor course for three days. RN C stated that she was assured by the rest home that she would be "treated as a learner". She said that she told the facility manager that the "workload was impossible", but was reassured that she was "just learning".

23. RN C said that during Mr A's residency at the rest home, she did not provide him with hands-on care, but did see him frequently when undertaking rounds, and often had interactions with his family during her rounds.

Care planning

Rest home policy — assessment and care planning

24. The rest home's policy on assessment and care planning provided the following:

- An initial nursing assessment and care plan to be completed in the first 24 hours of admission.
- A skin soft tissue wound integrity assessment to be completed within 24 hours of admission.
- A wound assessment form to be completed for residents who present with a wound. The wound is to be monitored through a wound monitoring form, which is to be used each time the dressing is changed, and photographs are to be taken.
- A short-term care plan to be initiated referring staff to the wound assessment and wound monitoring forms.

Initial nursing assessment and care plan

25. On the day of admission to the rest home (5 Month1), a registered nurse completed an initial nursing assessment and care plan. Under the heading "safety", Mr A is recorded as a falls risk, but the section for the "individual care required" is left blank. The "mobility" section also records Mr A as a falls risk and indicates that he mobilised with a walking stick and walker. Under the section "hygiene", Mr A was noted to require showering three times a week, with attention to his axilla, skin folds, toes, and groin areas. The

section on Mr A's need for any assistance with showering was left blank, as was the section on individual care for pain.

26. On admission, Mr A's weight was recorded as 85.4kg. On 21 Month1, the records state that Mr A was to be weighed monthly.

27. Mr A was prescribed paracetamol 500mg tablets, two tablets four times daily for pain relief. He was charted oxycodone hydrochloride[9] (oxycodone) 5mg PRN (as required) every four hours when necessary for moderate to severe pain. He remained on this prescription of oxycodone until 8 Month4, when he was charted morphine 10mg for breakthrough pain.

28. I acknowledge that Mr A had a history of dementia, and that on admission to the rest home he had delirium. However, this investigation has focussed on what I consider to be the primary issues regarding the standard of care provided to Mr A between Month1 and Month4, guided by the advice of RN Sheryl Lilly. Accordingly, I have not focussed on the management of Mr A's dementia and delirium during his time at the rest home.

Wound care plans on admission

29. On admission, a skin soft tissue wound integrity assessment was partially completed. It records five marks to the lower legs to indicate the location of the wounds. There is no description of the wounds or of the type of soft tissue involved, or of any skin integrity issues — the sections for skin integrity or types of wound are left blank.

30. On 5 Month1, a short-term care plan[10] was commenced in response to the skin integrity issues identified on admission. Under the section "nursing diagnosis", the plan notes that Mr A had bilateral lower limb oedema with multiple weeping lesions. The goal recorded was to maintain Mr A's skin integrity, and interventions included fluid restriction of one litre per day, elevation of his lower limb, an intake and output chart, and wound dressings for the lesion. There is no evidence that the short-term care plan was updated or evaluated further during Mr A's residency at the rest home.

31. A soft tissue care plan (STCP) was developed on 9 Month1 — four days after admission — for the cellulitis on both of Mr A's legs. The plan records the goal, type of injury, interventions, and evaluations of the wound. The section for description of the wound is left blank.

32. There is no evidence that a wound assessment form was completed, or that photographs of the leg wounds were taken in accordance with Heritage Lifecare's policy on the management of wounds.

GP review

33. On 7 Month1, General Practitioner (GP) Dr E reviewed Mr A and noted that he had been admitted for palliative care and had "gross lower leg oedema. No sign of infection."

[9] An opioid analgesic for moderate to severe pain.
[10] The short-term care plan records the description, intervention, and evaluation of a wound.

InterRAI assessment

34. On 11 Month1, an InterRAI[11] assessment was commenced, and was marked completed on 13 Month3. It states that Mr A had bilateral lower leg oedema, and required regular paracetamol for left leg pain. It also states that he required one-person assistance with showers three times a week, and supervision and cueing to maintain personal hygiene. It states that he mobilised independently with a walking frame, and required supervision for safety.

Resident lifestyle plan (long-term care plan)

35. On 21 Month1, a resident lifestyle plan (the lifestyle plan) was completed by a registered nurse. Under the section "Personal Care and Hygiene", it is recorded that Mr A required the assistance of one person with daily cares.

36. Under the section "Skin Integrity", the lifestyle plan states that Mr A had impaired integrity related to his weeping lower leg. It directs staff to apply dressings to Mr A's lower legs daily, owing to the weeping, and to report any changes in his skin to the GP.

37. Under the section "Pain/Comfort", it is noted: "[Mr A] will be regularly assessed and assisted [to maintain] his pain levels at 0/10 or at least at a comfortable level for him while in [the rest home]." The interventions/care record: "Assess the pain level regularly, Administer regular analgesics and PRN if required, Report the GP if the pain is not in control, Pain scale (0/4)."

38. The sections "Mobility" and "Maintaining Safety" note that Mr A was a falls risk owing to his peripheral oedema. Mr A's falls risk is described as "medium" in accordance with a Coombes assessment[12] on 3 Month1, prior to his admission to the rest home. The section "Maintaining Safety" notes Mr A as a mild to moderate risk for falls.

39. The section "Grief/Loss/End of Life" records: "[Mr A] has not decided on Advanced directives despite information given, need to be discuss[ed] later." The lifestyle plan does not record that Mr A was admitted to the rest home for palliative care.

40. The section "Elimination Bowels/Bladder" records that Mr A required assistance with bowel hygiene.

Personal cares

Record of personal cares

41. The record of personal cares indicates that during Mr A's residency at the rest home, generally he was showered once per week and, on occasion, twice weekly. It is recorded that Mr A was independent with some aspects of his personal cares, but required assistance with showering. The section "Nails, clean, cut" is left blank. There is no evidence in the record of personal cares that staff paid attention to Mr A's nails during his residency.

[11] Resident Assessment Instrument — a standardised instrument for evaluation of the needs, strengths, and preferences of a resident in long-term care.
[12] A falls risk assessment tool.

42. On 26 Month3, an episode of faecal soiling occurred, and a caregiver cleaned Mr A's legs of faeces. The following day, Mr A's family observed that Mr A had faeces on his body. There is no evidence in the record of personal cares that Mr A was showered on either 26 or 27 Month3, and the nursing notes do not document the incident of faecal soiling, or that Mr A's family raised concerns about this.

Weight loss

43. Mr A was weighed on 21 Month1, and at that time his weight was 85.4kg, which was unchanged from admission. A weight record form commenced in Month2 documented Mr A's weight as 75.9kg — a loss of 9.5kg since his admission on 5 Month1. There is no evidence that Mr A was weighed in Month3.

Falls

First fall — 2 Month2

44. The nursing notes on 2 Month2 record that at 8.00pm Mr A had an unwitnessed fall. An incident form was completed by RN D, who noted that Mr A's dressing on his left leg probably contributed to the fall. RN D assessed Mr A for injuries, and none were noted, and he denied any pain. She re-dressed the wound on his left leg to avoid further falls. RN C reviewed the incident form and recorded her instructions that staff should observe Mr A for increasing falls risk. RN C did not sign or date the incident form.

45. Later that day, RN D completed a nursing post-falls assessment and recorded that Mr A was not at risk of falls.

46. Between 3 and 9 Month2 (inclusive) there are no entries in the progress notes recorded by registered nurses. The rest home stated that the omissions by staff to record in the nursing notes is a departure from Heritage Lifecare's documentation policy and from accepted best practice.

47. On 11 Month2, the STCP records that a nurse dressed Mr A's leg wounds, and that he reported pain.

48. On 9, 11, and 12 Month2 there are no entries in the nursing notes.

Second fall — 16 Month2

49. At 9.00pm on 16 Month2, Mr A had an unwitnessed fall. Mr A told a nurse that he slipped and hit his head on the rubbish bin. The nursing notes state:

> "[Mr A found by a nurse with] a laceration on occipital region. No lump/obvious bleeding noted. Found epistaxis[13] for 2 seconds (approximately 5 ml) and no more later on. Commenced on Neuro[logical] obs[ervations]. [Blood pressure decreased] 81/60 mmHg."

50. At approximately 9.30pm, RN D reviewed Mr A and took his vital signs again. His blood pressure had increased to 91/60mmHg and his other observations were normal, and no

[13] Bleeding from the nose.

skin tear or injury was noted. RN D completed an incident form and notified Mr A's family of the fall. It was recorded that a possible contributing factor for the fall was Mr A's unsteady gait and "massive dressing on both legs". RN D encouraged fluids, elevated Mr A's feet, and commenced neurological observations and ongoing monitoring. It is documented that a landing mat and personal alarm were put in place. RN C evaluated the incident form and recorded that Mr A required close monitoring, and that he had refused to use a wheelchair as an option, as he preferred to walk.

51. A nursing post-falls assessment completed by RN D on 16 Month2 indicated that Mr A had a "medium–high risk" of falls.

52. The neurological observations form states: "Following an incident where a head injury may have occurred: ½ hourly observations for 2 hours, hourly for 4 hours and then daily for 4 days."

53. Mr A's neurological observations were recorded at 9.00pm, 9.30pm, and 10.00pm on 17 Month2, and at 7.00am and 11.00am on 18 Month2. There is no evidence that any further neurological observations were taken.

Third fall — 3 Month3

54. The nursing notes record that at 3.30pm on 3 Month3, Mr A was found on the floor by a caregiver. Mr A stated that he lost his balance and fell on the floor. The nursing notes document that Mr A hit his head on the floor and sustained a laceration on the right-hand side of his forehead.

55. Neurological observations were commenced at 2.30pm on 3 Month3, and an ice compression was applied. Neurological observations were recorded every 30 minutes until 4pm, hourly between 4pm and 10.00pm, and then at 1.00pm the following day. There is no evidence of any neurological observations having been performed after 1.00pm on 4 Month3.

56. An incident/accident form was completed by a nurse and evaluated and signed by RN C. It recorded a possible contributing factor for the fall as a "loss of balance, due [to] swollen leg & unsteady gait".

57. RN C noted that Mr A required continued close monitoring of his behaviour as he was known to be aggressive, and that he was "already high falls risk monitoring". She recorded that the post-falls assessment and neurological assessments were yet to be completed.

58. A nursing post-falls assessment completed on 8 Month3 in respect of the fall on 3 Month3 indicates that Mr A was at risk for falling.

Wound care and pain management

Wound care plan

59. An STCP was developed on 9 Month1 for the cellulitis identified on both Mr A's legs on admission. It states that Mr A's legs had blisters that were open, closed, and weeping, and required cleansing, dressings, and bandages.

Wound care dressings and pain management

60. The medication administration record states that at 5.30am on 10 Month1, Mr A was administered oxycodone 5mg/5ml for "leg pain", with the effectiveness noted as "settled". There is no record of a pain assessment having been completed on 10 Month1.

61. On 11 Month1, the clinical notes record that the dressing on Mr A's legs was evaluated by a nurse, but this was not recorded in the STCP.

62. On 11 and 18 Month1, Mr A was administered oxycodone for penile pain and generalised pain, respectively.

63. Mr A was reviewed by a GP on 18 and 22 Month1 owing to a red area on his left foot and an inflamed left knee. On 22 Month1 the GP noted that the left knee was more inflamed, and that the bilateral lower leg oedema continued. The GP planned to commence antibiotics.

64. The STCP records that in Month1, Mr A's wound dressings were changed on 16 occasions. The wound reviews between 17 and 26 Month1 recorded that Mr A required daily dressing changes. The STCP documents that usually dressings were changed every one or two days, but on one occasion it was four days between dressing changes. On the 16 occasions when the leg wound dressings were changed, a large amount of exudate was noted to be leaking from the wounds. Generally, Mr A reported that he had no pain when the dressings were changed.

Month2

65. Although it is documented that Mr A's wounds required daily dressing changes, in Month2 only 18 dressing changes are recorded.

66. The STCP shows that Mr A's pain levels were assessed each time a dressing change occurred. Usually Mr A's pain was assessed as between 0/10 and 3/10, although on 6 Month2 Mr A's pain was assessed as 5/10.

67. In Month2, Mr A was administered paracetamol up to four times daily for pain relief. However, there is no evidence that Mr A was offered oxycodone to manage his pain when his wound dressings were changed.

Month3

68. In Month3, only nine dressing changes are recorded in the STCP. The STCP records that usually there were three days between the dressing changes, but sometimes up to seven days. It was noted on each occasion that there was a large amount of exudate from the wounds.

69. On 1 Month3, Mr A reported pain of 8/10 during a dressing change. At 11.14am, he was given 2.5ml oxycodone 5mg/5ml oral liquid for pain management, and this was noted to be "effective".

70. On the same day, Dr E reviewed Mr A and recorded that he was stable, and that no changes to his medication were required.

71. A podiatry review was arranged for Mr A for 13 Month3, but this did not occur. The rest home stated that this was because a high number of residents had to be seen by the podiatrist that day.

72. On 21 Month3, the STCP records that a review of Mr A's leg wounds was required on 23 Month3, but it was a further seven days until the STCP was updated.

73. On 28 Month3, the STCP records that a review of Mr A's leg wounds was required on 2 Month4, but it was a further two days before the STCP was updated.

74. In Month3, generally the nursing notes were updated daily by caregivers or registered nurses, with the exception of 5, 6, 9, 16, and 23 Month3.

75. There is no evidence that during Mr A's residency, staff referred him to a GP for review of the management of his leg wounds.

Complaint made by Mr A's family

76. On 27 Month3, Ms B sent an email to RN C raising concerns that Mr A's bedroom was dirty with faeces, and about the frequency of staff rounds. RN C did not respond to Ms B's email, and subsequently it was deleted. RN C acknowledged that the email was deleted, but maintains that this was not deliberate, and that she has no recollection of deleting the email.

77. RN C acknowledged that she did not respond to Ms B's email sent on 27 Month3. RN C stated that instead she gave instructions to a nurse to inform her when Ms B was visiting, so that she could talk to her about the email. RN C told HDC that she did not adhere to the rest home complaints policy, and said that upon receiving Ms B's email she should have replied and acknowledged it.

Deterioration Month4

78. On 1 Month4, a GP reviewed Mr A owing to concerns about a rash on his groin. The GP prescribed Micreme[14] and recorded a plan to take a skin swab and, if indicated by the result, to commence antibiotics. The following day, another GP performed a monthly review of Mr A and recorded that he was stable and to continue on the current medications.

79. On 2 Month4, a caregiver recorded:

[14] For the treatment of skin infections.

> "[Mr A] had a big mess in his room. It was urine all over the floor. We did give him a shower. Inform RN on duty because all dressing was off. Took off himself. Settle in later after lunch but still a bit sleepy. All cares done."

80. On 5 Month4, the nursing notes state that Mr A's leg dressings were changed, but there is no documentation of the dressing change on the STCP.

6 Month4

81. On 6 Month4, a nurse changed Mr A's dressings on his lower leg. The nurse stated that Mr A's son was present while she was changing Mr A's dressings. She said that maggots were coming out from what appeared to be a necrotic piece of skin under Mr A's right toenail. It was recorded that Mr A described waves of pain through his body, for which he was administered PRN oxycodone. There is no record of a pain assessment having been completed. It was recorded that the family told a registered nurse: "[Mr A] may be in his final stages and they want him to be as comfortable as possible." The family waited to see the GP who was on rounds at the facility that day, but the GP was unable to meet with them owing to time constraints.

82. At 4.45pm on 6 Month4, the nursing notes state that Mr A's daughter, Ms B, was concerned that paracetamol was no longer addressing Mr A's pain adequately. Ms B asked to see the GP, and requested that staff check Mr A's feet twice daily for maggots, change his dressings daily, and clean his room daily. Ms B also asked staff to contact her if any changes in Mr A's condition were noted.

83. That day, a GP was undertaking rounds at the rest home, and a nurse recorded Mr A's name on the doctor's list requesting a review of Mr A's "R [right] foot big toe parasites maggots". However, the GP did not see Mr A that day, and the appointment was rescheduled for 8 Month4. The rest home said that a nurse who was accompanying the GP on the rounds deferred Mr A's appointment because the GP was waiting for the results of the swab taken from Mr A's groin rash on 1 Month4.

84. Later that day, it is recorded in the nursing notes that a nurse showered Mr A and noted that some maggots were present, and these were removed. The nurse documented that staff should "continue to check and clean the foot area and remove any maggots that may be present". The record of personal care contains no record of a shower having been given on this date.

85. RN C told HDC: "[A]t no time was I told about a deterioration in [Mr A's] condition or the presence of maggots."

86. The rest home told HDC that its escalation process provides that a registered nurse is to follow its "Deterioration in Health Status Procedure" and document any concerns on a handover sheet. The daily handover sheets are then reviewed daily by a unit coordinator, the clinical services manager, and the facility manager.

87. The rest home stated that the concerns raised by Ms B on 6 Month4 were not recorded in the clinical lead handover on 6 or 7 Month4. The rest home acknowledged that its staff

may not have escalated the concerns raised by Mr A's family to senior management in a timely manner.

7 Month4

88. On 7 Month4, Mr A was administered oxycodone at 5.00am, 2.50pm, and 7.24pm for pain relief. There is no record of a pain assessment having been completed when the oxycodone was administered.

89. On the same day, it was recorded in the progress notes and the STCP that Mr A was again found to have maggots under his right big toenail. The STCP records "Pain 5/10". The record of personal care notes that Mr A was assisted with a shower that day. The clinical handover form for 7 Month4 records that Mr A's family requested stronger regular medications for pain relief, and that they would be present for the GP visit on 8 Month4.

8 Month4

90. On the morning of 8 Month4, the nursing notes record that Mr A had been administered oxycodone and had had a settled night. No pain assessment was documented.

91. On 8 Month4, the STCP states that Mr A appeared to be in severe pain when moving his legs, and that he was administered morphine for pain.

92. On the same day, Mr A was seen by a podiatrist, who noted the history of maggots found on 6 Month4. She observed that Mr A had "high levels of pain with digit abduction", and attributed this to tinea pedis.[15] The podiatrist recorded "poor foot hygiene", and recommended that Mr A's feet be cleaned daily.

93. Also on 8 Month4, Dr E reviewed Mr A with his family present. Dr E noted that the family raised concern about Mr A's leg pain and the discovery of maggots under his right great toenail. Dr E also noted a marked deterioration in Mr A's level of consciousness and ability to swallow food. Dr E examined Mr A and noted that he was drowsy but was able to indicate leg pain when his legs were moved. Dr E recorded that there was an extensive discussion with the family. She documented her plan to prescribe Mr A 5mg midazolam[16] and 20mg morphine, and for Mr A to continue with a puréed diet. In response to the "information gathered", Ms B stated that prior to the GP's arrival, a family friend, who is also a nurse, told staff that Mr A required puréed food and morphine for pain relief. Ms B said that when the GP arrived, the family friend reiterated her advice about puréed food and pain relief, and raised concerns about Mr A's wounds. Ms B maintains that it was the family friend who alerted the rest home staff and the GP to Mr A's needs.

94. At 11.00pm on 8 Month4, a nurse cleaned Mr A's feet and changed his bandages. At 3.00am it was noted that Mr A was not very responsive. Mr A passed away at 3.30am on 9 Month4.

[15] An infection of the soles of the feet and the interdigital spaces, also known as "athlete's foot".
[16] A sedative.

Further information

Mr A's family

95. Ms B told HDC that Mr A was unable to request pain relief competently, and that this was communicated to the nursing staff on multiple occasions. She said that regular requests were made to the nursing staff to increase Mr A's pain relief, but this was dismissed by staff. In response to the "information gathered", Ms B stated that she made multiple requests to staff to arrange a GP review or podiatry review, but this did not occur. She said that the rest home's response to the flies in Mr A's room was inadequate, and so she provided automatic sprays, a fan, and a light cover to keep flies off Mr A.

RN C

96. RN C told HDC that since these events she has paid more attention to her documentation. She said that in Month3, an environmental audit was performed and "a large number of flies" were identified. She stated that the issue with flies was discussed with the facility manager, and efforts were made to eliminate them.

RN D

97. RN D acknowledged that there were gaps in the documentation, in particular the pain assessment. She stated that at the time of events there was no pain assessment tool to guide staff in their assessments. RN D told HDC that at the time of events she was not familiar with the rest home's policy on care plan documentation, and acknowledged that Mr A's care plan was inadequate.

Rest home

98. The rest home stated:

> "We sincerely apologise for any distress caused to [Mr A] and his family. It is never our intention for this to happen and we acknowledge the standard of care [Mr A] received was not acceptable, and that some staff departed from established policy and procedure while caring for him."

99. The rest home acknowledged that Mr A was unable to request pain relief, and that despite his family's request to increase his pain relief this did not occur. The rest home also stated that on some occasions, staff noted that Mr A was in pain when the dressings were changed, but PRN analgesics were not administered. It said that this was not in accordance with Heritage Lifecare procedures. The rest home noted that there was a lack of consistent documentation to indicate that pain was managed during dressing changes. It acknowledged that staff did not administer charted oxycodone to Mr A for pain relief when changing his dressings. The rest home stated that there was no evidence that the GP was consulted to chart the PRN oxycodone as a regular medication. The rest home acknowledged that "there was a lack of competence with wound management by the registered nurses".

Subsequent events

Clinical nurse specialist review

100. On 8 Month4, following a request from Heritage Lifecare, a clinical review of Mr A was conducted by a clinical nurse specialist from a community service for older people. The review highlighted failings in wound management and the evaluation and assessment of pain, inconsistent documentation, and poor communication with the family.

Heritage Lifecare internal review

101. In Month4, Heritage Lifecare conducted an internal investigation into the care provided to Mr A. The review found failings in assessment, communication, escalation of concerns, evaluation and assessment of pain, foot hygiene, and documentation.

Review

102. In Month4, the DHB completed a review of the rest home. The review found issues in relation to assessments, evaluation and recording of processes for pain, the presence of maggots in a wound, anecdotal evidence of faecal soiling in Mr A's room, and management of falls.

103. The review noted that on admission Mr A's weight was recorded as 85.4kg. It was recorded in the resident lifestyle plan that Mr A was to be weighed monthly. In Month2, a weight record form showed that Mr A had lost 9.5kg since admission. It was noted that there was no record of any evaluation that identified Mr A's weight loss, and no record that his weight was taken in Month3.

104. The review noted that on 18 Month1, Mr A was physically aggressive towards staff, and four staff were involved in the incident. The review found that this incident was not documented in Mr A's behaviour monitoring chart, and an incident form was not completed. It was found that Mr A's lifestyle plan was inadequate and did not provide appropriate guidance for its staff to manage his behaviour.

105. The review also noted that on 26 Month3, Mr A's family raised concerns with staff that during a visit, Mr A's bed, floor, and body had been soiled with faeces. The family also raised concerns that the following day Mr A had faeces on his body.

106. The review noted that on 26 Month3 a caregiver advised the facility manager that Mr A had had an episode of faecal soiling in his room. The caregiver said that Mr A's legs were cleaned of faeces, and that his room was also cleaned of any faeces. The review noted that there was no evidence that Mr A was showered on 26 Month3, or that this incident was recorded in the clinical records.

107. The preliminary report was shared with HealthCERT, and input was sought regarding compliance with the Health and Disability Services Standards.

Inspection of compliance with Health and Disability Services Standards

108. The Ministry of Health undertook an unannounced inspection of the rest home to determine whether the services being provided met the relevant Health and Disability

Services Standards (2008). The inspection found that the rest home did not fully comply with 10 of the Health and Disability Services Standards (2008). A Corrective Action Plan (CAP) was developed to address the areas identified within 30–180 days, and it was recommended that ongoing monitoring be undertaken by the DHB. The CAP made recommendations in the following areas: wound management; communication and complaint management; identification and management of risk; pain management; basic hygiene and cares; documentation; podiatry services; in-service education; falls management; end-of-life care; care planning and assessment; behaviour management; charting fluid/weight; quality improvement; pressure injury management; and incident and accident reporting.

Independent unannounced surveillance audit

109. An auditing service undertook an unannounced surveillance audit of the rest home. The audit noted that issues identified in the previous HealthCERT audit relating to governance, quality improvement process, reporting adverse events, staffing, activities programme, evaluation of residents' progress, and heating had been addressed. The audit found that improvements continue to be required in relation to assessment, care planning, and staff appraisals, and a further two new issues were identified as requiring improvement related to complaints management and staff handover processes.

Day-care services audit

110. Later that year, an auditing service undertook an audit of the rest home's day-care services.[17] The audit found partially attained areas rated as low to moderate risk. The audit noted that improvements were required in relation to whistleblowing systems; process with NASC;[18] day-care policy; an attendance agreement for day-care services; nutritional profile of residents; and a quality plan risk register. Corrective actions were required within three to six months.

Changes made since these events

111. The rest home told HDC that following the aforementioned reviews and audits, a CAP including 16 areas was developed, with oversight from the DHB. The rest home stated that a process for monitoring the CAP with the DHB was agreed.

112. The rest home stated that following these events it provided training to its staff in relation to caring for a deteriorating resident, wound management, falls prevention, and personal care and hygiene.

113. The rest home also told HDC that since these events it has made the following changes:

- Appointed a new manager for the facility.
- Increased staffing levels of registered nurses. One registered nurse is responsible for 30 residents in the hospital, and one registered nurse and an enrolled nurse are responsible for 60 residents in the rest home.

[17] A service user in the community who attends the rest home for day-care sessions.
[18] Needs Assessment and Service Coordination services.

- Increased staffing levels of unit coordinators.
- Implemented weekly unit coordinator meetings.
- Daily nursing handover sheets are emailed to the facility manager and clinical services manager for review, follow-up, and explanation as and when required.
- Implemented a designated registered nurse to be the wound management champion.
- Improved complaints management.
- Reviewed and updating its policies and internal audits as part of the quality programme.

114. In addition, a case study will be developed from this complaint, for educational purposes for all staff.

Relevant policies/procedures

115. The rest home's policy regarding complaints states:

> "All complaints, dates and actions taken are documented in the Complaints Register.
>
> …
>
> All concerns/complaints are to be acknowledged in writing within five working days of receipt of the complaint.
>
> …
>
> The facility manager is to be advised immediately when any complaint is received."

116. The rest home's policy regarding falls — prevention and management states:

> "Falls and hits head. B[lood] P[ressure] and R[espiratory] neuro[logical] obs[ervations] ½ hourly and for 2 hours. If stable neuro obs and pulse hourly for 4 h[ours] and then discontinue."

117. The rest home's policy regarding deterioration in health status states:

> "2. Procedure for registered nurse assessment
> …
>
> RN to establish status of resident
> …
>
> Establish details of illness or injury from Resident, Caregiver/Hospital Aide
> …
>
> RN to assess further according to priority:
> …
>
> Doctor or Ambulance

RN to contact Doctor OR RN to call for an ambulance

…

3. Procedure for contacting doctor

Registered Nurse has assessed resident and decided to seek Doctor's advice

Registered Nurse to check: Residents GP or On Call GP

…

RN to make contact with Doctor and record advice."

118. The rest home's wounds management policy states:

"…

Assessment of Wound

For residents presenting with a wound, a ***Wound Assessment Form*** is to be completed.

…

The ***Wound Monitoring form*** is to be used each time the dressing is changed and photographs taken.

…

Documentation requirements

Fill in incident form (if wound is the result of an incident or is a pressure injury)

…

Complete monthly indicators spreadsheet

Complete Wound Assessment Form

Record the fact in the residents notes that the wound has occurred.

Write a short term care plan (STCP) referring staff to the wound assessment and wound monitoring forms. Update the progress notes and any dressings record/s.

Evaluate the wound regularly and document on the Wound Monitoring Form.

When the wound has healed, complete the STCP

Complete the Wound Monitoring Form record and file it in the Resident's notes."

119. The rest home's policy regarding the management of pain provides:

> "Registered Nurses/Duty Leaders will document reported pain on each shift. A pain chart can be used to further document changes, at the request of management or Clinical Services Manager.
>
> The assessment of pain control will be part of the three monthly patient care review procedures, or more often as required to maintain good control.
>
> The Visiting Medical Practitioner will review the medication chart on each visit and evaluate the effectiveness of the treatment, referring to nursing notes for pain control.
>
> The Registered Nurses responsible for the long-term care plan will document all pain prevention measures.
>
> The Residents right to seek alternative therapies must be respected however the Resident's GP is to be informed.
>
> Where appropriate, referral to a Pain Management Specialist should occur."

Responses to provisional opinion

120. Ms B, Heritage Lifecare Limited, and RN C were all given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, changes have been incorporated into the report.

121. Ms B told HDC that the rest home was engaged to provide a service of care for her father — "end of life care to ensure his final days were comfortable and kind". Instead, Ms B considers that there was no dignity for her father in his final days at the rest home.

122. Heritage Lifecare Limited accepted the recommendations in the provisional opinion and provided an outline of the actions it would take to meet the recommendations, and provided a written apology for forwarding to Mr A's family.

123. RN C accepted the recommendations in the provisional opinion, and has provided a written apology for forwarding to Mr A's family.

Relevant standards

124. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.

…

4.7 Deliver care based on best available evidence and best practice.

4.8 Keep clear and accurate records.

4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines.

4.10 Practise in accordance with professional standards relating to safety and quality health care."

125. The New Zealand Health and Disability Services (General) Standard (NZHDSS) 1994[19] states:

"NZS 8134.1.2.2 Organisational management

Service Management

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

Opinion: Heritage Lifecare Limited — breach

126. In accordance with the Code of Health and Disability Services Consumers' Rights, Heritage Lifecare Limited had a duty to provide its residents with services of an appropriate standard. The NZHDSS requires 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.

127. Mr A required hospital-level care owing to the complexity of his needs, for his end-of-life care. This case highlights the importance of aged residential care facilities having staff with adequate expertise and skill to support residents with their end-of-life care needs, chronic medical conditions, and complex co-morbidities. In such circumstances, medical, nursing, and support staff need to be alert to a resident's changing health status. Staff must assess, think critically about, and respond appropriately to, deterioration in the resident's condition. In my view, Heritage Lifecare Limited failed in its duty to provide an appropriate standard of care to Mr A.

Pain management

128. On admission to the rest home on 5 Month1, Mr A's history of gout and arthritic pain, and the need for regular pain relief, were noted. However, Mr A's assessment on admission

[19] The New Zealand Health and Disability Services Standards are mandatory for relevant service-based contracts that receive health funding, including hospitals, rest homes, and some providers of residential disability care.

does not record the location of his pain, what caused or increased the pain, or the level or intensity of the pain. There are no instructions in the initial assessment and care plan to guide staff in their care and management of Mr A's pain.

129. The resident lifestyle plan completed on 21 Month1 also did not indicate a clear plan to manage Mr A's pain and guide staff in their care.

130. Mr A was given paracetamol up to four times daily to manage his pain. Despite having been prescribed oxycodone PRN (as required), he was given oxycodone on only four occasions for pain relief until 6 Month4, when the maggots on his toe were found. On the occasions when oxycodone was administered, the registered nurses evaluated the effectiveness of the pain relief, but there is no record of any pain assessments having been completed.

131. The short-term care plan shows that the registered nurses evaluated Mr A's pain levels during wound dressing changes, and noted the occasions on which he reported pain. However, there was no pain management plan for when Mr A reported pain during wound dressing changes. In his first three months at the rest home, Mr A was offered PRN pain relief for wound dressing changes on one occasion. It was not until Mr A's final days at the rest home that staff administered appropriate pain relief for wound dressings. The failure of the registered nurses to administer Mr A pain relief when he reported pain was a departure from Heritage Lifecare policy.

132. My expert, RN Sheryl Lilly, advised that the documentation in the resident lifestyle plan was inadequate. She stated that owing to Mr A's need for regular pain relief for his wounds, a penile infection, and palliative care needs, "there was an opportunity to better individualise the plan" in relation to Mr A's pain and his other needs.

133. I agree. I consider that neither the initial assessment and care plan nor the lifestyle plan were adequate to guide staff in their management of Mr A's pain.

134. RN Lilly stated that accepted best practice around pain assessment and management is to use a pain assessment tool to evaluate the pain, onset, duration, severity, and causes of the pain. She stated that a pain assessment can then inform a pain management plan to manage the resident's pain adequately.

135. RN Lilly advised that despite regular paracetamol, there were opportunities for further pain management. She advised:

> "Although there is evidence that his pain was monitored it was not fully investigated via a pain assessment tool. The nurses failed in their duty of care to then act on that information and evaluate the need for further pain relief."

136. Overall, RN Lilly considers that this represents a moderate departure from the accepted standards of care.

137. I accept RN Lilly's advice. Mr A was admitted to the rest home for end-of-life care, with significant co-morbidities, and it was unacceptable that he suffered unnecessarily in his last months. His family had stressed to staff their wish that he be comfortable in his final days. In my view, the rest home staff did not utilise pain assessment tools appropriately to assess Mr A's pain, and failed to manage Mr A's pain adequately when it was noted that his dressing changes were painful. Mr A had a history of dementia and delirium, and at times he may not have had the cognitive ability to convey in explicit terms the extent and nature of the discomfort he was experiencing. As such, staff should have been equipped to assess his pain independently and respond appropriately. Mr A should not have had to rely on his family to advocate on his behalf for such a fundamental component of his end-of-life care. Overall, this shows a lack of critical thinking by multiple registered nurses, and a lack of attention to, and recognition of, Mr A's needs for adequate pain management.

Palliative care

138. Mr A was admitted to the rest home for palliative care. However, the need for palliative care was not indicated in Mr A's resident lifestyle plan completed shortly after admission. This information was pertinent to guide staff in their care and planning for Mr A's final days. I am critical that staff failed to record in the resident lifestyle plan that Mr A was admitted for palliative care and, in my view, this contributed to the lack of attention to his palliative care needs.

Wound care management

139. A soft tissue wound assessment was completed for Mr A shortly after admission. It recorded the location of Mr A's wounds, but did not record information about the type of wounds or his skin integrity. The initial care plan completed on admission directed staff to monitor Mr A's skin and apply dressings to his lower legs.

140. A short-term care plan was completed on admission, but there was no evidence of a wound assessment to inform the care plan. The rest home stated that the failure to conduct a wound assessment to inform the short-term care plan completed on admission, or to take photographs of the wounds, is a departure from Heritage Lifecare policy.

141. An STCP was commenced on 9 Month1. Multiple registered nurses evaluated Mr A's wounds during dressing changes, and updated the STCP. The STCP records the required frequency for review of Mr A's dressings, but wound dressings were changed irregularly and infrequently. Generally, the wound dressings were changed daily, but sometimes it was up to seven days between dressing changes. The STCP did not instruct staff about which type of dressing to use, and there are instances when the dressing changes were recorded in the nursing notes but not in the STCP.

142. RN Lilly advised that a wound care plan is essential to guide the registered nurses about the type of wound care dressing and the frequency of dressing changes, to ensure continuity of wound care between changing shifts and staff. She stated that although there is evidence of partial planning and intervention, the wound care management

process was not complete, and this represents a moderate departure from accepted standards.

143. I accept RN Lilly's advice. It is unacceptable that Mr A's wounds were not reviewed as directed by the short-term care plan, and that at times there were several days between dressing changes. Staff did not utilise a wound assessment tool to assess Mr A's wounds, and failed to develop an adequate wound care plan to guide staff on dressing changes. In my view, this contributed to the poor wound care management by multiple staff.

Falls management

144. On admission, Mr A was identified as a falls risk in several different care plans.

145. During his time at the rest home, Mr A had three falls (2 Month2, 16 Month2, and 3 Month3). All three falls were recorded in incident/accident forms and the nursing notes. Following each fall, a nursing assessment was completed. It was noted that Mr A's bulky dressings and his refusal to use a wheelchair for his safety were contributing factors to his falls.

146. RN Lilly advised that the initial assessment and care plan should have stated the instructions for care staff on falls management for Mr A while a long-term care plan was being completed. She said that despite a falls risk being identified on admission, there is no evidence of a more in-depth falls assessment. RN Lilly advised that on admission, an in-depth falls risk assessment should have been completed to guide Mr A's care until the InterRAI assessment had been completed.

147. Following Mr A's falls on 16 Month2 and 3 Month3, staff commenced neurological observations. However, these did not continue over the timeframe required by Heritage Lifecare policy. RN Lilly advised that the neurological observations following the falls on 16 Month2 and 3 Month3 were inadequate. There is no indication that neurological observations were undertaken following Mr A's fall on 2 Month2.

148. RN Lilly noted that the post-falls assessments identified the contributing factors to the falls. However, Mr A's lifestyle care plan was not updated after each fall to inform the caregivers about the contributing factors identified and guide them to manage his falls risk.

149. RN Lilly advised:

> "The importance of critical thinking by a lead RN cannot be over emphasised. There appears to be a lack of follow up post fall to ensure that falls risk is lowered, this is primarily through the care plan which presumably caregivers are reading and can then follow through on."

150. RN Lilly considers that overall this represents a moderate departure from the standards of accepted practice.

151. I agree. In light of his identified falls risk, I am highly critical of the failure to perform an in-depth assessment of Mr A on admission. Pertinent information was not incorporated into his care plan to guide staff in their ongoing care of Mr A. In my view, these were missed opportunities to reduce the risk of further falls, and I consider that this shows a lack of critical thinking by multiple staff at the rest home. The monitoring of Mr A's neurological status following his falls was inadequate, and I am highly critical that multiple staff failed to adhere to the rest home's policy for observations. Overall, I consider that this shows a lack of critical thinking and poor adherence to policy, which placed Mr A's safety and well-being at risk.

Personal care and hygiene

152. Mr A's assessment on admission states that he required showers three times a week, with attention to his axilla, skin folds, toes, and groin. No information is recorded about what, if any, assistance Mr A required with showering.

153. Mr A's personal care record states that generally he had a shower once or twice a week; however, there is no evidence in the nursing notes or the personal care record that he received his scheduled showers.

154. The personal care record also contains no mention of any nail care provided. Mr A had a rash on his groin, for which Micreme was prescribed, but no short-term plan was commenced. On 8 Month4, a podiatrist reviewed Mr A and recorded that his foot hygiene was poor. At that time, Ms B raised concerns to staff about the hygiene of Mr A's feet and the cleanliness of his room.

155. Mr A's lifestyle plan indicates that he required assistance with bowel hygiene; however, there is no evidence in the nursing notes that staff provided any assistance to Mr A with bowel hygiene.

156. RN Lilly advised that it appears that Mr A's basic hygiene needs were met. However, she said that the documentation indicates that insufficient attention was given to Mr A's issues with his groin and nails. RN Lilly noted a lack of documentation of the reasons why Mr A did not receive showers in accordance with his assessment. She stated that it is unclear whether Mr A was offered showers, or refused them, owing to a lack of documentation.

157. In my view, it is more likely than not that Mr A's personal and hygiene cares were inadequate. In the absence of evidence to the contrary, I find that Mr A did not receive three showers a week as required, and was not provided with adequate assistance with his bowel hygiene or with his groin and nails. Mr A's family found him in very distressing circumstances, with faeces on his body and in his room. In his final days at the rest home, Mr A's foot hygiene was very poor, and maggots were found under his toenail. If Mr A had received appropriate care, including greater assistance with maintaining his personal hygiene, this could have been avoided.

Weight loss

158. I note the findings of the review of the rest home in relation to Mr A's weight. In Month2, staff recorded that Mr A had lost 9.5kg since his admission on 5 Month1, but did not evaluate his weight loss further. Staff should have weighed Mr A every month, but there is no evidence that he was weighed in Month3.

159. I am highly critical that staff failed to weigh Mr A every month and further evaluate his weight loss and intervene with appropriate measures when this was identified in Month2.

Escalation of a deteriorating patient

160. On 6 Month4, a registered nurse changed Mr A's leg wound dressings, and maggots were noted under his toenail. The nurse washed Mr A's feet, changed his dressings, and administered oxycodone for pain relief.

161. Mr A's daughter raised with a registered nurse her concerns about the management of Mr A's pain, the discovery of maggots, and Mr A's deterioration. Mr A's daughter also raised concerns that Mr A was in his final days, and requested a GP review. The nurse placed Mr A's name on the doctor's list of residents for review, but the GP did not see Mr A that day because another nurse rescheduled Mr A's appointment for two days later.

162. There is no evidence that staff documented the incident on 6 Month4 in either an incident form or handover sheet to escalate these concerns to RN C, or that staff informed RN C directly.

163. RN C maintains that she was not informed about the maggots on 6 Month4. She said that there was no documentation to alert her to this incident. However, from 6 Month4 until 8 Month4, the nursing notes and the short-term care plan record ongoing issues with maggots.

164. RN Lilly advised that it would have been appropriate for the nurse to notify RN C about the discovery of the maggots, the family concerns about Mr A's pain, and their request to meet with the GP on 6 Month4. RN Lilly said that each of these issues warranted escalation by nursing staff to the clinical services manager, RN C.

165. RN Lilly stated:

> "There appears to be room for improvement around communication systems in relation to on the floor RNs and their immediate direct report, the Clinical Nurse Manager, [RN C]."

166. RN Lilly considered that there was evidence of a "communication failure" at the rest home.

167. It is concerning that Mr A's deterioration was first observed by Mr A's daughter rather than the rest home staff. I am highly critical that the issues on 6 Month4 were not escalated to RN C, and of the standard of communication between the registered nurses and RN C. In my view, this points to an environment of inadequate critical thinking and

poor communication between the nurses who were providing direct care to Mr A, and the clinical services manager, RN C.

Nursing oversight

168. The clinical records indicate that a registered nurse oversaw Mr A's care following his admission in Month1. However, in Month2, there are no entries in the clinical notes by a registered nurse on 13 days. In Month3, on six days there are no entries by a registered nurse.

169. Heritage Lifecare policy requires a registered nurse to document the progress of hospital-level care residents in the clinical notes at least once daily. Heritage Lifecare acknowledged that its staff did not record entries in the nursing notes on every shift or daily.

170. Documentation is a key function of nursing care. In my view, a lack of documentation contributed to the failure of staff to recognise Mr A's actual condition, particularly in respect of pain management and wound care, and to provide appropriate interventions. I am highly critical that multiple registered nurses departed from the documentation requirements in Heritage Lifecare's policy. In my opinion, it is also indicative of a lack of awareness by multiple nurses as to Mr A's overall state of health, his deterioration, and the level of oversight that was warranted at this time.

171. The poor nursing oversight was compounded by inadequate staffing. At the time of these events, two registered nurses were responsible for the monitoring of 60 residents in the hospital-level wing, and for escalating any changes or concerns to senior staff.

172. RN Lilly advised:

> "I would not consider it feasible for 2 RNs to be able to successfully monitor [60 hospital-level wing] residents and report any changes or concerns to their superior on any one shift and this may be where the communication failure began in this Facility."

173. I accept RN Lilly's advice. I note that there were aspects of the care, in particular regarding monitoring and the reporting of changes, that were inadequate. I consider that overall it was the rest home's responsibility to ensure that the staffing levels were adequate to provide oversight for its residents. I am critical that this did not occur.

Conclusion

174. The rest home had the ultimate responsibility to ensure that Mr A received care that was of an appropriate standard and complied with the Code. I consider that the failure of multiple staff to provide Mr A with an appropriate standard of care points towards an environment that did not support and assist staff sufficiently to do what was required of them. It is unacceptable that a person at the end stage of life should be subject to such circumstances. Mr A had been referred to the rest home for palliative care. The service was aware of his complex medical conditions. As such, his care should have been planned

accordingly. I am concerned that several aspects of the care provided by the rest home were inadequate. In particular:

a) Multiple staff failed to provide appropriate assessments of Mr A's pain and provide adequate interventions to manage his pain, in particular during wound dressing changes.

b) The wound care assessments and care plans were inadequate and failed to guide staff in their care to provide appropriate interventions. Staff failed to document the wound care provided adequately.

c) Staff failed to manage Mr A's falls adequately, by failing to monitor his neurological status and update his care plans with pertinent information to guide staff to reduce the risk of further falls.

d) Mr A's personal cares and hygiene were inadequate. His physical environment was dirty.

e) Staff failed to monitor Mr A's weight regularly and evaluate his weight loss and intervene appropriately when this was identified in Month2.

f) Staff were alerted to Mr A's deteriorating condition but failed to escalate the change in his health status to the clinical services manager.

g) Staff failed to document Mr A's care and treatment consistently, and this was compounded by inadequate staffing levels.

175. For these reasons, I find that Heritage Lifecare Limited failed to provide Mr A with services of reasonable care and skill, and breached Right 4(1) of the Code. These failures meant that Heritage Lifecare Limited did not comply with the NZHDSS and, consequently, that Heritage Lifecare Limited also breached Right 4(2) of the Code.

176. I note that following these events, Heritage Lifecare Limited completed the actions recommended by the DHB for quality improvement, and that therefore some appropriate corrective measures have been undertaken to prevent a similar occurrence in the future.

177. RN Lilly advised that she applauds the continued improvements that the rest home has achieved since these events, notably the review of its policies and increased senior staffing to facilitate better communication and checking systems.

Opinion: RN C —breach

Introduction

178. RN C was employed by the rest home as the clinical services manager at the time of these events. RN C's position description states that she was responsible for (among other things) providing oversight of clinical records and documentation to ensure that it met any organisational and legislative requirements.

179. RN C told HDC that she did not provide any hands-on care for Mr A, but often spoke with him and Ms B during her rounds.

Complaint management

180. On 27 Month3, Ms B sent an email to RN C raising concerns that Mr A's bedroom was dirty with faeces, and regarding the frequency of staff rounds. RN C did not respond to Ms B's email, and subsequently it was deleted.

181. RN C acknowledged that she did not respond to Ms B's email sent on 27 Month3. RN C stated that instead she gave instructions to a nurse to inform her when Ms B was visiting, so that she could talk to her about the email. RN C told HDC that she did not adhere to the rest home's complaints policy, and said that upon receiving Ms B's email she should have replied to Ms B and acknowledged it.

182. RN C acknowledged that Ms B's email was deleted, but she maintains that deleting the email was not deliberate, and she has no recollection of deleting the email.

183. I am concerned that RN C failed to comply with the complaints policy by not responding to Ms B's email. While I acknowledge RN C's stated intention of discussing Ms B's concerns with her in person when she next visited, I do not consider that this was a suitable arrangement, as it was not possible for RN C to know how long it would be until Ms B's next visit. In my view, this was a missed opportunity for RN C to act on Ms B's concerns in a timely manner.

Oversight of Mr A's foot care — Month4

184. The progress notes from 6 Month4 record that there were maggots present on Mr A's toes, and that Mr A's family were concerned about this and had requested to be present for Mr A's next GP visit. The clinical handover form that was provided to RN C on 7 Month4 noted that Mr A's family would be present for his GP visit, and that they were requesting stronger medication for his pain relief. It did not reference the presence of maggots.

185. RN C told HDC that at no time was she informed of the maggots found on Mr A's toes, and there is no evidence that this was escalated to her by other nursing or caregiving staff. However, staff recorded in the STCP, nursing notes, and the doctor's list of residents for review that maggots were found on Mr A's toes between 6 and 8 Month4, and RN C's job description required her to oversee those records. My expert advisor, RN Lilly, stated:

> "[T]hese things should have been escalated to the Clinical Nurse Manager. However [RN C] states that there was no documentation received to alert her to the fact that [Mr A] had [m]aggots, these might have included an incident form, handover form, or direct communication from the RNs on the floor or the Facility Manager when she became aware of this situation … if this was the case then [RN C] could not have acted appropriately. If, however, [RN C] was careless in her duties as a clinical nurse manager and knowingly did not respond to the alerts then I would consider this a moderate to severe departure from standard of care."

186. I also note RN Lilly's comments that there was an opportunity for better communication with the nurses who reported to RN C. RN Lilly advised that she would not consider it feasible for two registered nurses to be able to monitor all residents (in 60 hospital beds) successfully and report changes or concerns to their superior on any one shift. She stated: "[T]his may be where the communication failure began in this facility."

187. Given the information available to me, I am unable to conclude whether RN C was made aware of the maggots on Mr A's toes by other nursing staff. However, I note that RN C was not alert to the issues about the maggots, despite this being recorded in the clinical records over three days. There were opportunities for RN C to be aware of the issue about the maggots. I am highly critical that this did not occur.

Oversight of clinical records

188. RN Lilly considered that neither Mr A's initial assessment and care plans completed on admission, nor the lifestyle care plan completed on 21 Month1, were adequate.

189. RN Lilly also noted that staff failed to complete the appropriate documentation for Mr A's pain management, and that no pain management plans or pain assessments were completed.

190. RN Lilly observed that Mr A's soft tissue wound assessment was partially completed, and advised that the wound plan to guide staff in their care was inadequate. The rest home stated that staff failed to complete a wound care assessment to inform the STCP, and that this was a departure from its policy.

191. As RN Lilly also notes, there is no evidence that Mr A had an in-depth falls risk assessment or a review of his care plan in response to his three falls. Although staff commenced neurological observations following two of his three falls, these were not continued in accordance with the rest home policy.

Conclusion

192. As the clinical services manager, it was RN C's responsibility to monitor the documentation of nursing plans and assessments, and ensure that reporting and evaluations were adequate. This was a key function of RN C's position. RN C was not alert to the issue about the maggots, although this was recorded in the nursing documentation. RN C failed to provide appropriate oversight of the nursing documentation and care planning to ensure that this was completed for Mr A. RN C failed

to comply with the complaints policy by not responding to Mr A's family. In my view, this placed Mr A's well-being at risk and contributed to the poor communication between staff about Mr A's palliative care needs, in particular his wound care and pain management. He did not receive the support and standard of care to which he was entitled. RN C failed to provide services to Mr A with reasonable care and skill in relation to clinical documentation, care planning, and communications. Accordingly, I find that RN C breached Right 4(1) of the Code.

Recommendations

193. In the provisional opinion, I recommended that RN C provide a written apology to Mr A's family for her breach of the Code. RN C has now provided an apology, which has been forwarded to the family.

194. I recommend that the Nursing Council of New Zealand consider undertaking a competence review of RN C.

195. Heritage Lifecare Limited has now provided an apology, which has been forwarded to Mr A's family. I recommend that Heritage Lifecare Limited:

a) Provide to HDC, within three months of the date of this report, an update on the actions taken to address any outstanding issues arising from the Corrective Action Plan.

b) Undertake an audit of its compliance with the protocols for registered nurses reporting changes in a resident's condition to senior staff.

c) Undertake a review of the rest home palliative care policies, and provide HDC with an update on the review within three months of the date of this report.

d) Use this report as a basis for training staff, and provide evidence of that training to HDC within six months of the date of this report.

e) Use the learnings and insights gained from Mr A's experience, and disseminate this opinion more widely among the care homes owned and operated by Heritage Lifecare Limited, within six months of the date of this report.

Follow-up actions

196. A copy of this report with details identifying parties removed, except the expert who advised on this case and Heritage Lifecare Limited, will be sent to the Nursing Council of New Zealand, which has been advised of RN C's name.

197. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Heritage Lifecare Limited, will be sent to the Ministry of Health (HealthCERT), the District Health Board, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Expert advice to the Commissioner

The following expert advice was obtained from RN Sheryl Lilly:

"I, Sheryl Lilly, have been asked to provide an opinion to the Commissioner on case number 18HDC00700 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.

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 twelve years and also own another 28 bed facility, that I purchased 6 years ago. I am also a Career Force assessor.

Instructions from the Commissioner
I have been asked to review the documentation sent to me and provide an opinion of the care provided by the rest home and Clinical Nurse Manager [RN C] to [Mr A]. In particular please comment on:

The adequacy of [Mr A's] pain management

The adequacy of [Mr A's] wound care management

The adequacy of management of [Mr A's] falls

The standard of care regarding [Mr A's] personal cares and hygiene

The standard of communication with [Mr A's] family

The adequacy of care provided to [Mr A] by [RN C]

The adequacy of corrective actions put in place at [the rest home] following this event

Any other matter in this case that you consider warrants comment

Factual summary
[Mr A] was admitted to [the rest home] on the 5th [Month1] for palliative management. He had an indwelling catheter and leg wounds requiring regular dressings. On 6th [Month4] a nurse changing [Mr A's] dressing noted maggots under his toe nail. [Mr A's] family raised concerns to [the rest home] staff about his wound care and pain management. [Mr A] was seen by a GP and podiatrist on the 8th [Month4]. The GP prescribed midazolam and morphine via syringe driver and discussed [Mr A's] deteriorating condition with the family. [Mr A] died the following day. [Mr A's] daughter, Ms B has complained to HDC about the standard of care provided to [Mr A] during his admission to [the rest home].

Expert Review

1.The adequacy of [Mr A's] pain management

[Mr A] was admitted on the 5th [Month1] and an initial nursing assessment and care plan template was populated on that day[1]. Under the heading of pain, a tick indicated that [Mr A] was on regular pain relief, he had a history of Gout and Arthritic pain. There is no indication of what causes the pain, its location or severity. There are no instructions for care under the individual care pertaining to [Mr A's] pain. [Mr A's] lifestyle plan around pain was not well documented considering the need for regular pain relief, his wounds, a subsequent penile infection and being admitted for palliative care. The opportunity to better individualise the lifestyle plan is apparent not only around pain but other needs as well. [Mr A's] pain was monitored during his wound dressings, however there was no pain management plan for when his wound dressings were painful, as sometimes indicated on the Soft Tissue Care Plan, and there is no record of PRN pain relief being administered during the dressings until the last days of life.

[Mr A] was charted regular Panadol and the OneChart Medication record indicates this was given as charted. He was also charted Oxycodone PRN, which was used on several occasions with reason for giving and noted outcomes that indicated whether the medication was effective or not, however there is no record of pain assessments being completed during any episodes of complaints of pain. Accepted Best practice around Pain assessment and management is to use a Pain Assessment Tool such as the Socrates Pain Scale or the McGill Short form Assessment Tool, both of which use scores to evaluate site, onset, duration, severity, and causes of pain. A pain management plan can then be established to better manage the resident's pain.

After reviewing the evidence, and considering that [Mr A] was given regular pain relief as charted but there was room for further pain management, I consider that there has been a moderate departure from accepted practice and duty of care. Although there is evidence that his pain was monitored it was not fully investigated via a pain assessment tool. The nurses failed in their duty of care[2] to then act on that information and evaluate the need for further pain relief.

2. The adequacy of [Mr A's] wound care management.

On admission [Mr A] had a Soft Tissue Wound assessment partially completed.[3] The template was not populated fully with missing information around the type of wound and the actual skin integrity. There was an indication of the placement of the wounds. The care plan indicates the need to monitor [Mr A's] delicate skin and to apply dressings to both lower legs. Accepted best practice for wound management is to complete a full wound assessment using a tool that includes assessment around type, size, depth of the wound, as well as the general condition of the surrounding skin and the general health of the person. A wound management plan could then be

[1] Heritage Lifecare 5c1 Initial nursing assessment
[2] www.nzno.org.nz
[3] 5C1 initial nursing assessment

established and goals set and then reviewed on a regular basis to establish if the plan is meeting the goals. The wound plan is necessary to guide RNs around the type of dressings to be used and the regularity of the dressing; this ensures continuity of wound care between changing shifts and staff. There is evidence of evaluation of the wound at each dressing including pain, ooze, colour, temperature, necrosis; these are prompted by the Soft Tissue care plan, however the plan does not instruct the RN around type of dressing and regularity of dressing clearly. The dressings appear to have been done on an irregular basis. I recommend that [the rest home] establish a wound leader that assesses plans and evaluates the wound on a regular basis, using benchmarking tools such as measuring of the wounds, or photos to help evaluate progress or lack thereof. Although there is evidence of partial planning, and intervention, the wound management process was not completed and I consider this a moderate departure from accepted practice.

3. *The adequacy of management of [Mr A's] falls.*

The initial assessment and care plan done for [Mr A] on the 5th [Month1] noted under Safety, that he was a falls risk; there were no individual care instructions to guide caregivers on falls management for [Mr A] while a long term care plan was being completed, there is also no record of a more in-depth falls assessment. Falls risk was also triggered in the long term InterRAI assessment. [Mr A's] Resident Lifestyle Plan[4] written on the 21st [Month1] also noted that he had a '*mild–moderate risk for falls'.* I sighted no Coombes risk assessment as indicated to be used in the Lifestyle Plan. There is evidence of Incidents/Accidents forms and Nursing Assessment Post Fall documents[5] being completed after each fall. There is evidence that contributing factors that could have caused the falls were considered, specifically his bulky wound dressing[6] and his non conformance in regard to using a wheelchair for his own safety[7], however [Mr A's] care plan was not updated to notify caregivers of these contributing factors and how they could be managed. A sensor mat and personal alarm were also used as tools to reduce the falls risk. It is considered best practice to use an in-depth falls risk assessment tool, such as the Coombes assessment during a resident's initial admission and then be guided by assessment triggers once the InterRAI assessment tool has been completed within a three week post admission period.

There is no record of an initial in-depth falls assessment having been done despite a falls risk being identified on admission. Although the care plan recognises the falls risk and has some interventions, there is no evidence of updating the interventions as a result of the post fall assessments. I also note that the fall on the 16 [Month2] and the 3 [Month3] involved the knocking of [Mr A's] head and ensuing neurological observations being commenced, however, they were not continued for an accepted period of time in either case as directed by [the] head injury policy. Considering that [Mr A's] falls risk was recognised and contributing factors identified after his falls, but

[4] Heritage Lifecare 5C9 Resident Lifestyle Plan
[5] Heritage Lifecare 6F2 Nursing Assessment Post fall
[6] 8B4 form dated 2 Month2
[7] 8B4 form dated 16 Month2

not clearly followed up through the care plan, and that neurological observations were not fully completed as per the facilities policy but there was evidence of correct procedures being followed in relation to documentation, communication with the family after each fall and the progress notes were completed. Although there is an impressive array of documentation required after a fall, the importance of critical thinking by a lead RN cannot be over emphasised. There appears to be a lack of follow up post fall to ensure that falls risk is lowered, this is primarily through communication through the care plan which presumably caregivers are reading and can then follow through on. A sensor mat and personal alarm are only there to alert caregivers to movement; it does not alone prevent the fall.

I consider the management of [Mr A's] falls were not completely adequate and was a moderate departure from accepted practice. I would recommend that a review of policies and procedure around neurological observations should be undertaken considering the importance of monitoring head injuries for at least 24 hours, particularly in the frail elderly resident, and as they were not followed as per [the rest home] policy.

4.The standard of care regarding [Mr A's] personal cares and hygiene

[Mr A's] assessment on admission indicates that he is to have a shower three times weekly in the morning, with special attention to his Axilla, skin folds, toes and groin. It does not indicate if [Mr A] requires assistance or how much. Assessment comments from LTCF InterRAI indicate that he requires one person assist for personal hygiene and dressing. His Lifestyle plan documents the need for assistance, supervision or cueing for various hygiene needs. [Mr A's] record of personal care shows that he had a shower at least once a week, sometimes twice a week, there is no indication in his progress notes as to whether he refused his scheduled shower or it simply was not done. The record of personal care shows that he was a mix of either independent or needed assistance with his other hygiene needs. I note that there is no record around nail care, either fingernails or toenails for the duration of his stay. There is no mention of bowel hygiene in the progress notes despite the Lifestyle plan indicating the need for help after a bowel motion. There is no reporting in the progress notes around [Mr A's] skin despite ongoing issues around rash in the groin, and no short term care plan around this. On reviewing [Mr A's] lifestyle plan and his progress notes, including the personal care log, it appears his basic hygiene needs were met; however, attention to his issues with his groin were not documented and there was a lack of explanation as to why [Mr A] did not receive his scheduled showers, and it is unclear whether this contributed to maggots appearing on his feet. I consider the standard of care regarding [Mr A's] personal care and hygiene was adequate, but there was room for improvement using subjective documentation around how caregivers met his hygiene needs.

5.The standard of communication with [Mr A's] family

It was established on admission that [Mr A's] daughter was his EPOA for personal care and welfare. There is clear documentation [8] each time there was family communication up until the 1 [Month4], however progress notes record continuation of communication around [Mr A's] deteriorating condition; this is also evident in the Doctors notes[9] on the 8 [Month4]. There is evidence that the family was contacted after an incident or accident, as this was noted on the incident/accident form. Apart from the clinical nurse manager not replying to an email, the reason being unclear, the standard of communication with [Mr A's] family meets accepted practice.

6. The adequacy of care provided to [Mr A] by [RN C].

There is no written documentation for me to refer to apart from [RN C's] response to HDC dated []. My comments, therefore, are only based on [RN C's] written statements. [RN C] states '*I did not provide any hands on care for [Mr A], but often spoke with him and [his daughter] during my rounds'.* [RN C] acknowledges that she failed to successfully communicate with [Mr A's] family when she was sent several emails and apologises in her statement. She is sure that she discussed the issues with staff at the time however. [RN C] writes about her usual day[10]; this includes following up on issues on the emailed handover form and any concerns regarding adequate care provisions and staffing issues. [RN C] states[11] that at no time was she informed of the maggots found on [Mr A's] toes. [RN C] states there was a clinical handover form that was last submitted to [RN C] on the 7 [Month4] stating [Mr A's] family will be present for his GP visit, the family are requesting stronger regular medications for pain, and he slept well. Documentation in the progress notes dated 6th [Month4] evidences family concerns around pain and the discovery of maggots, and the request to meet with the GP. All these things should have been escalated to the Clinical Nurse Manager. However [RN C] states there was no documentation received to alert her to the fact that [Mr A] had maggots; these might have included incident form, handover form, or direct communication from the RNs on the floor or the facility manager when she became aware of this situation via the media. If this was the case, then [RN C] could not have acted appropriately. If, however, [RN C] was careless in her duties as a clinical nurse manager and knowingly did not respond to the alerts then I would consider this a moderate to severe departure from standard of care. There was opportunity for better communication with her RNs, that may have alerted her to [Mr A's] foot issues since progress notes indicate that the maggot issue started on the 6th [Month4] and was ongoing until [Mr A's] death and [RN C] states she was unaware of the issue. Of note, [RN C's] written response[12] evidences her understanding of the role of a Registered Nurse who is not practising in direct clinical care[13]. There appears to be room for improvement around communication systems in relation to on the floor

[8] 5C19 family-whānau communication record.
[9] 5E8 Doctors Treatment notes
[10] Pg 12 [RN C's] response to HDC
[11] Pg 5 [RN C's] response to HDC
[12] Pg11 [RN C's] response to HDC
[13] New Zealand Nursing Council Competencies.

RNs and their immediate direct report, the Clinical Nurse Manager, [RN C]. I note that in [the rest home's] response[14] they roster two registered nurses for 60 hospital beds; I would not consider it feasible for 2 RNs to be able to successfully monitor all residents and report any changes or concerns to their superior on any one shift and this may be where the communication failure began in this facility. I would strongly recommend a communication system analysis to determine the adequacy of reporting.

7. The adequacy of corrective actions put in place at [the rest home] following this event.

On reviewing the Corrective Action Plan, there is evidence of some improvement in some areas, for example staff communication and family/resident complaints management, however in other areas such as care plans, use of pain assessment tools, documentation, falls management, wound management, that were all identified as lacking in this complaint have still not been fully addressed.[15] Considering the [rest home] has acknowledged this I consider it a minor departure from expected practice and would recommend that further outside supervision be continued to ensure accountability going forward with the ongoing corrective action plan.

Any other matter in this case that you consider warrants comment.

[Mr A] was admitted for palliative care. There was no indication in his Lifestyle plan around this. There is an opportunity to review [the rest home] palliative care policies to ensure residents' palliative needs will be met. This includes advanced care plans, pain management and family communication, two of which came up in this complaint. This will ensure that the last days of life are managed in a caring, clear and professional way.

Sheryl Lilly RN."

The following further advice was obtained from RN Lilly on 27 September 2019:

"I have been asked to review my advice in regards to [Mr A's] care by [the rest home].

After reviewing the documents provided to me I do not wish to alter my previous advice.

I have also been asked to comment on [the] policies in place, both at the time of the event and currently.

All policies that I read have been reviewed by [the rest home] since the time of the event. It is not always clear what changes have been made during those reviews, however I have noted the following:

[14] [The rest home] response appendix 8: staffing.
[15] Corrective action plan.

Management of Wounds Policy:

Issued 2016, reviewed 2018. This policy covers the definition of a wound, wound types, assessment, planning, intervention and evaluation. It also includes documentation requirements including wound assessment form and short term care plans templates. The wound assessment policy was reviewed in 2019 and shows expansion on original wound policy showing clear responsibility and accountability including monitoring overall wound outcomes more accurately and clearly states the need for outside wound expert advice when wounds are not healing. There is evidence of a Wound Assessment Audit issued in 2019, which covers all facets of the wound policy, this audit should ensure that wounds are correctly managed and meet best practice standards.

Complaints Procedure Policy

At the time of the event, the policy ensured the person making the complaint was respected, and the complaint was documented appropriately in the complaints file, with a time frame that the manager should respond to the complaint within. It stated a resolution should be sought or if necessary be escalated to the next level. Residents and families are required to be informed of the complaint process during admission; there was room for improvement with follow up and a continued improvement plan if necessary after the resolution of a complaint.

The complaints procedure was then reviewed in 2019; this evidenced an improvement in wording around staff responsibility and accountability. It shows a better infrastructure allowing staff to better understand their role in the complaints process, the time frames are more clearly set out and corrective actions are sought and implemented as a result of the investigation.

Falls Prevention Policy

This policy was issued in 2014 and last reviewed December. The policy indicates clear roles around the prevention of falls for all levels of staff. The falls prevention programme is robust and includes risk level assessment, care planning and evaluation with clear guidelines around required documentation. Post fall assessment and management is also clear and concise with the inclusion of the need for neurological observations for suspected head injury sustained from a fall with clear explanation around the Glasgow Coma Scale. I consider this policy meets standard practice.

Pain Assessment and Management Policy and Procedure

This policy was issued in … and reviewed in … It covers assessment using appropriate pain assessment tools, effective pain management using monitoring charts and responsibilities and accountability of staff. There has been an audit tool issued in … to review the pain policy compliance. I consider this policy appropriate and meets standard practice.

Deterioration of Health Status Procedure

This procedure was last reviewed March. There is a clear flow chart to ensure staff have a good understanding of the process and their role in that process. There is

reference to documentation requirements and the importance of family communication. This procedure is appropriate and meets standard practice.

There is a new Escalation Policy … This evidences clear pathways, depending on the level of risk to the resident, that ensure an incident is dealt with in the correct manner; it is, however, very dependent on good communication amongst the varying levels of staff in the facility.

Further Comment

I applaud the continued improvements that [the rest home has] achieved since the event of [Mr A][16] including having increased senior staff members on the floor to facilitate better communication and checking systems that should lead to better care of their residents. The two Registered Nurses who provided further reflection both commented on the improvement of orientation, communication, education and support from the management level that they feel has led them to be better nurses and therefore provide better care."

[16] Rest home written response […]