Rest Home

Registered Nurse, RN C

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC00915)

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Executive summary

1. Mrs A has insulin-dependent diabetes and a complex medical history. At the time of these events, her daughter, Ms B, held an enduring power of attorney (EPOA) as to Mrs A's care and welfare; the EPOA had not been activated.

2. On 1 November 2010, Mrs A (then aged 70 years) was admitted into the Residential Care Unit (RCU) at a rest home, having fractured her left neck of femur the previous month. She remained in the RCU until March 2012, during which time she was also under the care of a number of external providers through the Diabetes service. Registered nurse (RN) Ms C was the RCU Manager.

3. There were numerous issues with the implementation of aspects of Mrs A's care plan by rest home staff, including in relation to her diabetes management, wound care, falls and mobility assistance, and infection control.

4. Mrs A's diabetic care plan provided for two-hourly monitoring of her blood glucose levels following the administration of correction doses of insulin. It did not specify when ketone testing was to be done. The requirement for two-hourly monitoring was overlooked by rest home staff and therefore was not implemented. The requirement for ketone testing was not clarified until March 2012, some 15 months after Mrs A's admission to the RCU.

5. Mrs A had 15 falls during her time in the RCU. Rest home staff failed to implement a physiotherapy exercise regimen between 30 November and 9 December 2011.

6. Mrs A had a wound care plan set by her podiatrist, which provided that her heel ulcer was to be cleansed with saline and dressed with Aquacel[1] on alternate days. Rest home staff instead implemented a rotation of Aquacel, manuka honey and dock leaf poultice to treat Mrs A's heel ulcer. Mrs A's wound care records indicate that her heel ulcer was not dressed on alternate days, which RN C submitted was "more a problem of non-recording".

7. Mrs A's care was complicated by her non-compliance with some aspects of her care plan. Progress notes indicate that, on occasion, Mrs A would eat non-diabetic food, attempt to walk unassisted, and refuse to wear foam boots or use bed rails and/or lifting belts.

8. On 2 February 2012, RN C met with Ms B to discuss Mrs A's care and Ms B's concern that "specialist recommendations" were not being fully implemented into Mrs A's care.

9. On 12 February 2012, Mrs A fell while walking unassisted and fractured her right neck of femur. She was then transferred to the public hospital.

10. On 28 February 2012, while Mrs A remained in the public hospital, RN C met with Ms B. A Restraint/Enabler plan was signed by Ms B as EPOA. It was not signed by

[1] Silver sulphadiazine.

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Mrs A. A short-term care plan was documented, which provided that (among other things) Mrs A was to have two-person mobility assistance at all times, and that a urine test was to be completed within seven days of Mrs A's catheter being removed.

11. On 29 February 2012, Mrs A returned to the RCU. RN C was on leave, and RN Ms I was acting RCU Manager during RN C's month of absence. Between 29 February and 29 March 2012, Ms B attended two meetings with RN I and made six complaints to the rest home. Ms B noted that rest home staff had failed to perform a urine test following removal of Mrs A's catheter, and had not completed Mrs A's food diary accurately, and Ms B had observed caregivers mobilising Mrs A without the assistance of a second caregiver, and administering insulin without gloves. Ms B had also observed Mrs A in bed without her foam boots on.

12. On 29 March 2012, Mrs A was transferred to another facility, where she continues to reside.

Findings

13. RN C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[2] by failing to provide services to Mrs A with reasonable care and skill, in that she overlooked the requirement for two-hourly blood glucose monitoring and failed to clarify the requirements for ketone testing as part of Mrs A's diabetic care plan.

14. RN C breached Right 6(1)[3] and Right 7(1)[4] of the Code with regard to both the treatment of Mrs A's heel ulcer and the use of restraint, in that she failed to provide Mrs A with information that a reasonable person in Mrs A's circumstances would expect to receive, with the result that Mrs A was unable to make an informed choice and give informed consent to those aspects of her treatment.

15. The rest home breached Right 4(1) of the Code by failing to provide services to Mrs A with reasonable care and skill, in that various staff members failed to implement aspects of her care plan appropriately, including in relation to her diabetes management, mobility assistance and infection control.

16. The rest home breached Right 4(2) of the Code[5] by failing to provide services to Mrs A in accordance with professional standards, in that its documentation was suboptimal with regard to both the frequency of Mrs A's dressing changes and details of her non-compliance with aspects of her care plan.

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

[3] Right 6(1) of the Code provides that "[e]very consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"

[4] Right 7(1) of the Code provides that "[s]ervices may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise".

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

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Complaint and investigation

17. The Commissioner received a complaint from Ms B regarding services provided to her mother, Mrs A, at a rest home. Mrs A supports the complaint.

18. The following issue was identified for investigation:

Whether the rest home provided adequate and appropriate care to Mrs A between November 2010 and March 2012.

19. On 24 October 2013, the investigation was extended to include the following issue:

Whether registered nurse RN C provided adequate and appropriate care to Mrs A between November 2010 and March 2012.

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

21. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant
Rest home owner/operator	
Ms C	Registered nurse/Care Unit Manager

22. Information was received from the above parties and from:

Dr D	General practitioner
District Health Board	

23. The following people are also mentioned in this report:

Dr E	Endocrinologist
Ms F	Clinical Nurse Specialist (Diabetes)
Ms G	Podiatrist
Ms H	Podiatrist
RN I	Registered nurse/Acting RCU Manager (March 2012)
RN J	Registered nurse
RN K	Registered nurse
Ms L	Woundcare nurse
Ms M	Advocate
Mr N	General manager
Ms O	Caregiver
Dr P	General practitioner
Rest Home 2	Mrs A's current rest home

24. Independent expert advice was obtained from registered nurse (RN) Julia Russell (**Appendix A**).

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Information gathered during investigation

Mrs A

25. Mrs A has insulin-dependent Type 2 diabetes and a complex medical history.[6] She is also ESBL positive[7] with a history of pressure ulcers on her left heel.

26. Mrs A lived in an independent unit within the rest home. On 3 September 2010, she fell and fractured her left neck of femur (NOF).[8] On 14 October 2010, Mrs A was assessed as requiring rest-home level care and, on 1 November 2010, she was discharged from hospital and admitted into the Residential Care Unit (RCU) at the rest home. Mrs A was 70 years old.

27. Mrs A remained in the RCU until 29 March 2012, when she transferred to another facility (Rest Home 2), where she continues to reside.

28. During her residence in the RCU, Mrs A was also under the care of a number of external providers, including endocrinologist Dr E, Clinical Nurse Specialist (CNS) (Diabetes) Ms F, and podiatrists Ms H and Ms G of the diabetes service. From 2 November 2010, Mrs A was also under the care of the attending general practitioner (GP) at the rest home, Dr D, of the local medical centre.

Mrs A's legal status

29. On 30 September 2010, Mrs A signed a document appointing her daughter, Ms B, enduring power of attorney (EPOA) as to her personal care and welfare. The rest home told HDC that Mrs A "was never clinically or legally assessed as being incapable of acting in her own best interest. A certificate stating incapacity was never issued."

30. Ms B told HDC that Mrs A sometimes gives unreliable answers and is unable to make decisions when she is unwell. Dr D told HDC: "We came to understand that many of [Mrs A's] responses, although expressed confidently, were factually inaccurate."

The rest home

31. The rest home provides services to residents requiring rest-home and hospital-level care. The rest home includes the RCU as well as independent and semi-independent property options.

[6] Including peripheral vascular disease, diabetic ketoacidosis, hypertension, hyperlipidaemia, ischaemic heart disease, short-term memory loss and retinopathy.
[7] Extended Spectrum Beta Lactamase (ESBLs) are enzymes produced by some bacteria and germs, which make them resistant to antibiotics. People who are identified as being ESBL positive require infection control measures to be put in place to ensure that the bacteria do not spread.
[8] Hip fracture.

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Manager Residential Care Unit — RN C

32. RN C was the manager of the RCU during Mrs A's residence there. RN C is also a classical homeopath.[9] RN C told HDC that she was on leave for the month of March 2012, during which time RN I was acting RCU Manager.

33. The position description for the RCU Manager records that the purpose of the position is to "effectively manage the Residential Care Unit as a quality continuing care environment, and viable business …". General responsibilities include:

- ensuring the maintenance of safe, efficient and effective nursing practice;
- promoting a safe environment for residents, visitors and staff;
- ensuring the safe delivery and administration of all medications; and
- ensuring adequate staff coverage of the home and effectively managing and implementing a relevant continuing education programme for all staff.

34. Key management areas include ensuring staff education regarding infection control, monitoring the evaluation of care plans, monitoring all adverse events and falls, managing all aspects of safe staffing, and co-ordinating the registered nursing team (including maintaining daily oversight of registered nurses).

Ms B

35. In her complaint to HDC, Ms B raised a number of concerns with the services provided to her mother throughout the time she was in the RCU, including in relation to Mrs A's diabetes management, wound care, falls and mobility assistance, and infection control. For ease of reference, this report will set out the background to each of these matters separately before canvassing the events that took place in the two months leading up to Mrs A's discharge from the RCU on 29 March 2012.

Care planning

Rest Home Policy — Care planning

36. The rest home's policy on care planning provided:

> "Each resident must have the following documentation.
>
> - On the day of admission the Registered Nurse will complete the Nursing History and Care Plan Assessment.
> - From this information an Initial Care Plan is completed to immediately guide the Caregiving staff.
> - Long Term Care Plan will be completed within two weeks and updated three monthly, or as required.
> - Short Term Care Plan will be initiated for acute care changes such as wound care."

[9] A form of homeopathy in which the remedy consists of highly diluted animal, drug, plant, or mineral substances that most closely match the essence of the malady and the totality of symptoms.

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Initial assessment and care plan

37. On the day of Mrs A's admission to the RCU (1 November 2010), RN J completed an Admission Assessment and Initial Care Plan for Mrs A, which recorded that Mrs A had a high falls risk, could walk short distances with a frame and the assistance of one person, and she required a diabetic diet,[10] blood glucose level (BGL) monitoring and standard infection control precautions.

Personal care plan

38. On 8 November 2010, RN J completed a Personal Care Plan for Mrs A. The plan recorded:

- Mrs A was to walk with a frame and required two-person transfer assistance. She also required supervision while walking, cot sides to be up while in bed,[11] and a lifting belt[12] was to be used whenever mobilising, standing or transferring.
- Mrs A required a diabetic diet, insulin "as charted"[13] and BGL monitoring.
- Staff were to wear gloves and an apron while doing Mrs A's cares, and her clothes were to be washed separately from other residents' clothes, for infection control purposes.
- Mrs A's pressure sore was to be dressed every three days. She was also to wear foam boots and keep her foot off her mattress while in bed.

39. The Personal Care Plan further recorded that Mrs A has a "very close bond with daughter [Ms B]" and that Ms B was to be informed of any concerns and be allowed to be involved in Mrs A's care.

Care plan reviews and short-term care plans

40. Between November 2010 and March 2012, Mrs A's Personal Care Plan was reviewed four times. These reviews occurred on 19 February 2011, 15 May 2011, 8 August 2011 and 27 November 2011. From 6 December 2011, a series of short-term care plans were documented for Mrs A.

Diabetes management

Diabetic care plan

41. On 4 November 2010, clinical nurse specialist (CNS) Ms F visited Mrs A at the RCU to review her diabetes management. On 5 November 2010, a plan was documented for Mrs A's insulin and correction regimen.[14]

42. The plan recorded that Mrs A's BGL was to be tested before each meal, at 2am, and two hourly after any correction dose of Novarapid had been given. Mrs A's

[10] A nutritional profile was also completed, which recorded that Mrs A required a diabetic diet.
[11] The rest home has not provided any restraint documentation in support of this aspect of Mrs A's care plan.
[12] A belt used to lift and manoeuvre patients safely while reducing the risk of back injury to providers.
[13] Her insulin regimen was entered into her regular medication chart on 2 November 2010.
[14] Mrs A's insulin regimen provided for a set dose of insulin (Lantus) in the morning, with set doses of fast-acting insulin (Novarapid) throughout the day at meal times. Mrs A's correction regimen provided for set amounts of Novarapid to be administered when her BGL rose above 10mmol/L.

HDC

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documented diabetic care plan did not specify when Mrs A was to be tested for ketones.[15]

43. Ms B recalls that "on many occasions a careplan was issued by [the] diabetic team as to when Ketones should be tested", and provided HDC with an undated ketone management plan for Mrs A signed by Dr E. The DHB provided HDC with a copy of the same undated management plan. A copy of the plan was not included in the documentation provided by the rest home to HDC.

Monitoring of blood glucose levels

44. Insulin and BGL Recording Sheets (BGL records) indicate that during Mrs A's time in the RCU she was given set units of Lantus in the morning, followed by set doses of Novarapid throughout the day. Her BGL was taken and recorded when insulin was given and, in most instances, at 2am.[16]

45. The rest home told HDC that it accepts that the requirement for two-hourly monitoring following a correction dose was "not consistently followed". RN C told HDC that this requirement was particular to Mrs A and out of the ordinary in terms of general clinical management of diabetes, and that as a result it "slipped through". Ms B told HDC that RN C "knew from day one [that] this was to happen".

46. RN C explained that Mrs A's diabetic care plan was provided by the Diabetes service and that, although the requirement for two-hourly monitoring following a correction dose was in the documentation, it was not specifically brought to RN C's attention. RN C stated that she cannot recall any communication with the CNS regarding the need for two-hourly monitoring.

47. BGL records confirm that two-hourly monitoring of Mrs A was not initiated as a matter of course following the administration of correction doses,[17] although it did occur on occasion.[18]

Management of urinary tract infection — 21 to 23 December 2011

<u>21 December 2011</u>

48. On 21 December 2011, progress notes record that Mrs A felt "nauseated, clammy" and was taking antibiotics for a urinary tract infection. Over the course of the morning, Mrs A's BGL had risen from 18.4mmol/L at 9am to 29.6mmol/L at 11.05am.[19] Mrs A was described as "vomiting up tea, shaky".

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[15] Ketone testing measures the level of ketones in blood or urine. The presence of ketones can be an indicator of diabetic ketoacidosis, a life-threatening condition that occurs when there is insufficient insulin in the body to enable it to use glucose as a fuel source.

[16] Mrs A's 2am BGL readings are not documented in the BGL record on the following dates: 3 and 5 November (documented in progress notes), 25 and 29 December 2010, 22 January, 23 and 28 February, 20 March and 21 November 2011.

[17] For example, BGL records indicate that correction doses were given on the following dates without two-hourly monitoring: 3 to 10, 12 to 15, 17 to 20 and 25 to 28 November 2010.

[18] BGL records indicate that two-hourly monitoring was done on 16, 21 and 30 November 2010, 21 May, 19 and 27 June, 7 August, 1 September and 21 to 27 December 2011, 12 January, 17 and 24 March 2012.

[19] Progress notes record that Mrs A's BGL was checked at 9am, 10.20am, 11.05am and 11.50am that morning.

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49. At 11.20am, RN K recorded in the notes that she had spoken with Ms B about Mrs A's condition, and that Ms B felt that "[Mrs A] should be sent to [the public hospital]". Ms B told HDC that she recalls asking every day from 21 December 2011 for Mrs A to be taken to the public hospital.

50. Medical centre notes record that at 11.45am on 21 December, Mrs A's condition was discussed with Dr D, and that he considered that she was "OK to be transferred to hospital if family wishes".

51. At midday, RN K spoke with Ms B again and noted, "All vitals are going down. [Ms B] is on her way to visit." At 2.35pm, Mrs A was noted to be "up and about" and feeling "much better".[20] By 10pm, her BGL had reduced to 13.3mmol/L. BGL records indicate that Mrs A's BGL was checked three times overnight.[21]

<u>22 December 2011</u>

52. On 22 December 2011, RN J recorded in Mrs A's progress notes, "First thing, [Mrs A] felt cold, clammy, had pain in her head (not a headache), she felt nauseous and looked pale." At 7.35am, her recorded BGL was 13.2mmol/L. Mrs A's BGL then ranged between 18.0mmol/L and 20.0mmol/L over the course of the morning, with varying ketone levels.[22] BGL records indicate that Mrs A's levels began to reduce over the course of the afternoon.[23]

53. Dr D's notes record that on 22 December 2011 he visited Mrs A and assessed her as improving. Dr D told HDC: "I found her to be moderately unwell … She did not have evidence of progressive respiratory or urine infection." The time of Dr D's assessment is not recorded.

54. RN J recorded in the notes: "[Ms B] wants her mum to go to [Hospital] and will take her tomorrow if [BGL] still not settled." The progress notes record that Ms B was "very angry with what was 'going on'" and that she was "very upset that nothing was being done like blood tests or a catheter to get urine".

55. RN C recorded that at 10.30am she telephoned the Diabetic Clinic to "run through [Mrs A's] present progress". RN C recorded that she spoke with Ms H, who advised: "You are managing the situation — continue to monitor and adjust correction doses."[24]

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[20] Progress notes record that Mrs A's BGL was checked at 1pm and 2.35pm, by which time it had reduced to 14.9mmol/L.

[21] At 12.05am, 2.34am and 4.10am, Mrs A's BGL was recorded as 10.3mmol/L, 9.6mmol/L and 10.5mmol/L respectively.

[22] By 9am, Mrs A's BGL had increased to 18.0mmol/L with ketone levels of 0.2. At 10.15am, her BGL had increased further to 20.0mmol/L with ketone levels of 0.1.

[23] At 12.00pm, 4.20pm and 4.57pm, Mrs A's BGL was recorded as 13.5mmol/L, 4.0mmol/L and 5.2mmol/L respectively.

[24] RN C subsequently clarified to HDC that the name 'Ms H' was a "mistake of recording", and that she contacted the Diabetes Clinic (not the Podiatry Clinic). Ms B told HDC that she believes that RN C lied about contacting the Diabetes Clinic, and that the Diabetes Clinic did not make a file note of any contact with RN C on that day.

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56. RN C recorded that at 5pm on 22 December 2011 she had a "very angry, abus[ive] phone call" with Ms B regarding Mrs A's care. RN C noted that she advised Ms B that staff would continue to monitor Mrs A overnight. Ms B told HDC that she recalls receiving a phone call from RN C, at which time she asked for Mrs A to be transferred to hospital. Ms B recalls being told that RCU staff were monitoring Mrs A, and that Dr D did not think that Mrs A needed to go to hospital. Ms B told HDC that she was angry because her mother's BGL had not been taken on time and demanded that this be done.

23 December 2011

57. Mrs A's progress notes record that her BGL remained within "normal ranges" overnight.[25] RN C told HDC that Mrs A was recovering well at that point. Progress notes indicate that Mrs A was up for breakfast.

58. Ms B stated that on 23 December 2011 she went into the RCU and told RN J that she was taking Mrs A to hospital. Ms B recalls that RN J was not happy about Mrs A being taken to hospital. RN C told HDC that she got a "real shock" when Ms B arrived at the RCU and said that she was taking Mrs A to hospital.

59. Ms B told HDC that she then found Mrs A hanging off the side of her bed, "completely wet" and unable to get off her bed safely. Ms B recalls that she rang the bell for assistance twice, but no one came to help, and that she therefore called an ambulance. Ms B told HDC that her mother did not express a desire to go to hospital. However, Ms B thinks that her mother agreed with her when she said she wanted to take her to hospital. Mrs A stated that she cannot recall this incident.

60. RN C told HDC: "[Ms B] had already decided that she wanted a second opinion and thus insisted on transfer to Hospital despite the assessment by both myself and the St John's attendant that [Mrs A's] diabetes was stable. We could not calm her down enough to talk to her." The rest home told HDC: "It was felt, based on our observations, the presentation did not warrant urgent transfer to hospital."

61. Mrs A was taken to hospital by ambulance and discharged back to the RCU later that night with no acute problems requiring admission. Dr D told HDC that he does not know why Mrs A was transferred to hospital.

Diabetic diet

62. Ms B told HDC that she spoke to RN C "ten plus times" about the lack of variety in Mrs A's diabetic diet. Ms B was also concerned that Mrs A was given non-diabetic food by rest home staff.

63. RN C told HDC that the cook liaised with Mrs A regarding her diet (with oversight from the dietitian). RN C explained that although there is no record of these consultations with Mrs A, it did happen frequently. As RN C described it, the cook would have a chat with Mrs A.

[25] BGL records indicate that Mrs A's levels were checked four times between midnight and 7.40am on 23 December 2011, during which time her BGL ranged between 5.2mmol/L and 9.2mmol/L.

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64. Progress notes indicate that, on occasion, Mrs A was given non-diabetic food by rest home staff. For example, on 1 April 2011, it was recorded in Mrs A's progress notes that she had been given Milo, "which she is not suppose[d] to drink". Similarly, on 24 June 2011 a caregiver noted, "I was giving out cake and forgot [Mrs A] was not suppose[d] to have any. She had 2 small pieces." Ms B is of the view that incidents such as these were often not recorded by staff.

65. Progress notes also indicate that, on occasion, Mrs A would take non-diabetic food from other residents. For example, on 5 March 2011 it was recorded that Mrs A "needs watching at meal times — took [another resident's] dessert that [the resident] didn't want". On 16 April 2011, it was noted that Mrs A had "reached across and pinched" another resident's chocolate slice.

66. On 9 June 2011, RN K recorded a short-term care plan to address Mrs A's weight gain since admission. RN K recorded that Mrs A "takes other people's food" and that staff were to be aware of Mrs A's eating habits. RN C stated that the level of monitoring of elderly patients with diabetes is constant. RN C explained that she was mindful not to isolate Mrs A, and that Mrs A therefore needed to be with the other residents but out of reach of their food.

Falls, mobility assistance and restraint

Falls — 3 November 2010 to 21 September 2011

67. Mrs A stated that she recalls having many falls during her residency at the RCU (although she cannot recall how they happened) and that she would "always" try to walk around. Mrs A stated: "I like to be independent but I'm not."

68. On 3 November 2010, Mrs A fell whilst being transferred by a caregiver from her walking frame to her wheelchair. An adverse event form was completed. RN J recorded in the form that Mrs A required "2 person transfer using the lifting belt for safety".

69. On 13 November 2010, Mrs A was found on the floor, having fallen while attempting to walk on her own from her lounge chair to the dining room. An adverse event form was completed, which recorded that Mrs A had been asked not to walk on her own. RN J also noted in the form: "[Mrs A] wishes to be independent but is not yet able to walk independently."

70. On 18 November 2010, Mrs A was found sitting on the floor next to her bed calling for help. An adverse event form was completed, which recorded that Mrs A had no apparent injuries. RN C also noted on the form that she had a discussion with Ms B on 19 November 2010. RN C recorded:

> "[Ms B] asking that [Mrs A] be restrained with bedrails and lapbelt[26] when in wheelchair. [Mrs A] is too aware, she will undo it, she is also really likely to climb over the bedrails. She is moving herself more than [Ms B] thinks she is. Agreed to withhold restraint for now and alert staff to her high risk of falls, and need for

[26] A form of wheelchair-based physical restraint.

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supervision and assistance for all transfers. The above written into progress notes."[27]

71. On 30 November 2010, Mrs A refused to have her bedrails put up. An adverse event form was completed, which recorded that Mrs A "insisted bed rail stay down. Said she is not a baby and will scream if I put it up. I said [Ms B] wants the rails up when you are in bed she said stuff her I will scream." RN C noted on the form that "as there is no permission or documentation the bedrails are not to go up".

72. On 10 December 2010, an adverse event form was completed which recorded that Mrs A had been visiting another resident in the resident's room and "after a while" she walked back to her room unsupervised where she then lost control of her walker. The form further noted: "Staff to be aware that [Mrs A] will walk by herself & is a high fall risk. I have spoken with [Mrs A] about walking alone but she forgets."

73. On 22 January 2011, Mrs A fell while trying to get her walker. An adverse event form was completed, which noted that Mrs A had been given a bell to alert caregivers when she required assistance.

74. Progress notes record that on 24 January 2011, RN J had a discussion with Ms B about Mrs A attempting to walk on her own. RN J recorded: "[Ms B] said [Mrs A] has a hand bell in her walker, please ensure that this bell is visible and accessible when [Mrs A] is in the lounge."

75. On 26 January 2011, Mrs A fell while being assisted to stand. An adverse event form was completed, which noted: "Caregivers must use lifting belt to prevent injuries to themselves and to help prevent major injury to resident." Mrs A's progress notes record that on 27 January 2011 the lifting belt was used, although Mrs A told caregiving staff that she did not need it. On 28 January 2011, it was recorded in Mrs A's progress notes that she had tried to refuse the use of the lifting belt.[28]

76. Mrs A's progress notes for 1 February 2011 record that she had stood up from the toilet and walked to her bed even though her walker had been removed from her reach. It was further noted that "she didn't ring the bell and said she was 'trying to improve her progress'".

77. On 11 February 2011, Mrs A was found sitting by the telephone having walked there from her room unsupervised. An adverse event form was completed, which recorded that Mrs A had been given a bell but did not use it. The form further noted: "All [caregivers] need to be aware that [Mrs A] doesn't always remember what she's told & gets very frustrated with her lack of mobility. Always make sure she has access to a bell (electric or manual). Observe whenever you're in vicinity that [Mrs A] is OK."

78. On 18 February 2011, an adverse event form was completed, which recorded that caregiving staff heard someone calling out and that Mrs A was then found sitting on the floor of the lounge. The form recorded: "It is not determined if [Mrs A] had her

[27] Mrs A's progress notes for 19 November 2010 are missing from her clinical file.
[28] The remainder of the entry made in Mrs A's progress notes on 28 January 2011 is missing from her clinical file.

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wee hand bell with her to summons assistance. She must have the bell with her at all times."

79. Mrs A's progress notes record that during the morning shift of 19 February 2011, she was found "standing from her chair about to walk". It was noted that she had her bell beside her and had not used it.

80. On 11 March 2011, Mrs A fell while walking unassisted. An adverse event form was completed, which recorded that Mrs A had asked another resident to give her her walking frame, following which she "walk[ed] off on her own". RN K signed the adverse event form and noted: "[Mrs A] forgets she is not to walk unassisted. Constant awareness of her needs and assist PRN [as required]." RN K further recorded that she discussed the incident with Ms B on 16 March 2011, and that "[Ms B] is aware [Mrs A] walks alone and firmly asked her mother to ask for assistance. [Ms B] also wants [Mrs A] to be walked regularly rather than sit in chair for 2 or more hours."

81. On 24 March 2011, Mrs A fell while walking unassisted when her caregiver left the room for a few minutes. An adverse event form was completed, which recorded that "[Mrs A] will always be difficult to supervise and her actions are impromptu. Observations, interventions required PRN by all staff."

82. On 21 April 2011, Mrs A fell while being assisted to walk with a lifting belt. An adverse event form was completed, which recorded: "Always need assistance for walking. Need lifting belt."

83. On 3 June 2011, Mrs A fell while trying to reach for her call bell. An adverse event form was completed, which recorded that Mrs A was encouraged to wait for assistance from staff, and that staff were to ensure that Mrs A's call bell was within reach.

84. On 1 and 22 July 2011 and on 21 September 2011 Mrs A fell while being assisted. Adverse event forms were completed for each incident, which recorded that Mrs A had lost her balance and/or her leg(s) had given way while walking.

85. Mrs A's BGL record indicates that her BGL was not checked after her falls. Adverse event forms indicate that Ms B was advised of four of the above falls (on 18 November 2010 and 22 January, 11 March and 21 April 2011) at the time they occurred. HDC asked RN C why Ms B was advised of some falls and not of others. RN C explained that staff would have seen Ms B and spoken with her, although it was not recorded. RN C stated that Ms B would have been aware of most of the incidents, but acknowledged that there would have been some falls that she did not know about.

Physiotherapy

86. On 22 November 2011, Mrs A was admitted to a private hospital for surgery to remove a rod from her left hip (which had been inserted when she broke her NOF in September 2010). Mrs A returned to the RCU on 29 November 2011.

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87. Ms B stated that RCU staff failed to implement Mrs A's physiotherapy regimen for two weeks following her discharge. RN C told HDC that her recollection was that this issue had been raised in relation to Mrs A's rehabilitation following her release from the public hospital after her second fractured NOF in February 2012, and not in relation to her rehabilitation following her release from the private hospital in November 2011.

88. Progress notes indicate that on 30 November 2011 Mrs A was seen by a physiotherapist, who recorded that Mrs A was to walk regularly with her frame and be encouraged to "walk tall". Specific exercises were not recorded in the progress notes.

89. Between 1 and 9 December 2011, progress notes indicate that Mrs A was walking short distances. From 10 December 2011, progress notes regularly record that Mrs A's exercises had been completed.

90. Notes taken of a meeting held on 2 February 2012 between RN C and Ms B record that RN C "acknowledge[d] the caregivers did not put the exercise plan in place for two weeks. Exercise plan now in place."

Wound care and management

Wound care plan

91. During her residency in the RCU, Mrs A attended the Diabetes Podiatry Clinic seven times regarding treatment of her heel ulcer. Ms B recalls attending all but one of Mrs A's podiatry appointments. The treatment plan provided by podiatrists Ms H and Ms G called for the ulcer to be cleansed with saline, dressed with Aquacel and sterile gauze and bandaged,[29] on alternate days, and that Mrs A was to wear foam boots while in bed.

92. On 2 November 2010, RN J documented a wound care management plan for Mrs A's heel ulcer, which provided that it was to be cleansed with saline and dressed every three days.

93. On 4 February 2011, Mrs A's wound care management was amended to read, "cleanse & apply honey, tulle and gauze", every two to three days. In her interview with HDC, RN C explained that the RCU (in consultation with Dr D) uses a rotation of dock leaf poultice, Aquacel and manuka honey for wound care and management.

94. Dr D told HDC that during 2011, Mrs A's heel ulcer was treated with "long periods of regular, frequently changed conventional dressings" and a "short period of dock leaf poultices". Dr D stated:

> "[RN C], Nurse Manager, is an experienced, capable, caring expert nurse. She also has naturopathic and homeopathic knowledge. With chronic conditions where conventional therapy is not quickly resolving problems [RN C] may suggest trialling one of her alternative therapies. Providing there is no absolute contra-indication I do not object."

[29] On 4 April 2011, the Podiatry Clinic advised the RCU that bandaging was no longer necessary.

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95. RN C stated that dock leaf poultice had been used in rotation with Aquacel and manuka honey at the rest home for 12 years on skin tears where there is a topical infection or concern about anaerobic bacteria. RN C advised that the dock leaf poultice is an alternative medicine that is made by her and sourced from her organic farm. She explained that Mrs A and Ms B would have understood it as an alternative medicine from the nature of the product.

96. RN C explained that she would not have had a detailed conversation with Mrs A about why different dressings were being used, but that Mrs A would have been aware of what dressings were being used through general conversation. RN C recalls that there was a lot of discussion with Ms B about how often dressings were being done and what was being used. RN C told HDC that, initially, Ms B was not supportive of the use of dock leaf poultice, but was not negative either.

97. Ms B told HDC that she found out about the use of dock leaf poultice through a conversation with RN C after it had been commenced. Ms B recalls being told that the poultice was working well, and that she therefore went along with it.

98. Mrs A told HDC that the staff at the rest home did not discuss the treatment of her ulcer with her.

99. The management of Mrs A's pressure ulcer was recorded in a wound care management table, which included the date, time and details of the evaluation and dressing of the wound.

Dressings

100. On 23 March 2011, RN K noted in Mrs A's wound care management record: "Please do dock leaf poultice on next dressing." This was the earliest reference to dock leaf poultice recorded in the documentation provided by the rest home to HDC. The next entry in Mrs A's wound care management record does not specify whether dock leaf poultice was used.

101. On 4 April 2011, Mrs A was assessed at the Podiatry Clinic. In her letter to Dr D, Ms G noted: "Please ensure the site remains dry between dressing changes, and continue with Aquacel and sterile gauze … Alternate day dressing changes, thank you." Mrs A's wound care management plan was amended that day to read: "[C]leanse [with] saline, apply aquacel gel …"

102. On 9 April 2011, following receipt of a dressing plan forwarded to the RCU by the Podiatry Clinic at Ms B's request, RN J recorded a dressing plan within Mrs A's wound care management record to cleanse with saline and apply Aquacel and gauze.[30] Mrs A's wound care management records indicate that her heel ulcer was then dressed with Aquacel on 11, 17, 21 and 23 April 2011.[31]

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[30] This dressing plan was included in the documentation provided to HDC by Ms B, but not in the documentation provided by the rest home.

[31] A further entry made on 25 April 2011 records that the wound was packed with Paranet.

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103. On 27 April, wound management records indicate that Mrs A's heel ulcer was packed with dock leaf poultice, Paranet and gauze, and that there was "a little inflammation, some pain on touching". The next entry, made on 30 April, records that the wound was again packed with dock leaf poultice, Paranet and gauze, and that there was "pain on packing wound".

104. On 2 May 2011, Mrs A was assessed at the Podiatry Clinic. In her letter to Dr D, podiatrist Ms H reiterated the dressing plan and recorded:

> "Unfortunately the dressing plan from last visit was not followed and we would appreciate if aquacel Ag which has been supplied is used until finished and then resume with plain aquacel. There needs to be consistency with the dressing being applied to the wound as the jelonet/paraffin dressing[32] is too moist."

105. On 2 May 2011, RN C recorded in Mrs A's progress notes: "[Ms B] really upset after podiatrist visit, please do [Mrs A's] dressing, alternate days, as per dressing plan."

106. The following day, RN C documented a new wound care plan as directed by Ms H. Between 4 and 25 May 2011, a different wound monitoring form was completed, which recorded various assessments of the wound (such as wound dimensions, odour, pain and infection). The specific dressings used were not recorded on the form.

107. On 5 May 2011, progress notes record that Mrs A was seen by Dr D, together with RN C, RN J and Ms B. RN J noted: "A discussion was held around [Mrs A's] care and the role of each team member. The outcome is that the community wound resource will be asked to review [Mrs A's] foot and advise re dressing." In her interview with HDC, Ms B advised that at this meeting she and Mrs A told them to stop using the dock leaf poultice and to follow the podiatrist's care plan.

108. The rest home told HDC: "We acknowledge there was a discussion with [Ms B] during which [Ms B] expressed a view that alternative medications [were] not to be used. This should have been documented."

109. On 25 May 2011, it was noted in Mrs A's care plan that dock leaf poultice had been applied to her heel ulcer. On 27 May 2011, a further entry noted: "Sorry, did not see above, today Aquacel applied." Also on 27 May, RN J recorded in Mrs A's progress notes that she had spoken with wound-care nurse Ms L, who advised that rest home staff ought to be using ordinary Aquacel on Mrs A's heel ulcer.

110. From 27 May 2011, a different wound monitoring form was completed, which records the specific dressings used. That form records that the wound was dressed with Aquacel 17 times up to 29 June 2011, at which time it was noted that the wound appeared to be healed and that, following discussion with RN C, the wound was to be dressed with Paranet and gauze. Mrs A's wound care plan was updated.

[32] Non-medicated paraffin gauze dressing (tulle dressing).

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111. On 14 July 2011, Mrs A was seen at the Podiatry Clinic. In a letter to the rest home, Ms H noted that the wound had almost healed, and recommended dressing with Betadine, sterile gauze and Hypafix on alternate days.

112. On 15 August 2011, the Podiatry Clinic advised the rest home that the wound had healed, and that there was no further need for dressings to be applied (although it was recommended that Mrs A continue wearing her foam boots at night).

Frequency of dressings

113. Between 2 November 2010 and 2 May 2011, during which time Mrs A's wound care plan required her heel ulcer to be dressed every three days, 49 entries were made in her wound care management record by various staff members. The dates of 15 of the entries are more than three days after the last recorded entry.[33]

114. Between 4 and 25 May 2011, a different wound monitoring form was used, in which 12 entries were made. Mrs A's care plan during this time required dressings on alternate days. One entry made in that form was dated three days after the last recorded entry.[34]

115. Between 27 May and 17 August 2011, a different wound monitoring form was used. Mrs A's care plan continued to require dressings on alternate days. Of the 40 entries made in that form, six were dated more than one full day after the last recorded entry.[35]

116. RN C told HDC that this was "more a problem of non-recording than [dressings] not being done". She explained that she was involved in Mrs A's wound care and therefore was aware that the dressings were being done, but that when there is one registered nurse covering all residents, documentation is the thing that slides. RN C recalls that Mrs A's dressings were done in tandem with another resident on alternate days to doctor visits (which occurred on Tuesdays and Thursdays). RN C submitted that the end result (that is, the healing of the ulcer) shows that the dressings were done. She noted that for people with diabetes, pressure ulcers heal "against the odds".

Foam boots

117. Part of the management plan for Mrs A's heel ulcer was for her to wear foam boots while in bed, which are designed to ensure that there is no pressure on the area. Ms B stated that sometimes Mrs A would wear the boots, but at other times she would not want to wear them. Ms B is concerned that the caregivers did not know how to fit the boots correctly, and said that she would sometimes find that the boots had twisted on Mrs A's feet.

118. RN C told HDC that it was obvious how to use the boots, and that there was only one way to put them on. She also said:

> "Boots on and off were an ongoing issue, they were hot and sweaty, [Mrs A] could not get comfortable and she could not get off the bed with them on. She

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[33] Details of the recorded dates are set out in Appendix B.
[34] An entry was made on 8 May 2011. The next recorded entry was on 11 May 2011, three days later.
[35] Details of the recorded dates are set out in Appendix B.

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wore them the majority of the time and at times they were off because she became really upset if we insisted."

119. The rest home told HDC:

"The issue appears to have resulted when [Mrs A] had a different viewpoint re the wearing of the boots from her daughter. [Mrs A] was explicit in her wish not to wear these as she found them hot and restrictive. The issue appears to be that we did not accurately document this in a way that demonstrated her choice. The solution taken was to utilise an electric air mattress on her bed to reduce the risk of pressure on her heels. Staff did attempt to follow [Ms B's] request, however [Mrs A] was adamant on occasions that she did not want to wear the boots."

120. Progress notes indicate that Mrs A refused to wear her foam boots on occasion,[36] but do not indicate when the foam boots and/or the air mattress were used.

Infection control

121. Ms B stated that she and Mrs A were concerned by the lack of infection control measures put in place at the RCU with regard to Mrs A's ESBL positive status. Ms B stated that RCU staff did not wash their hands before performing Mrs A's cares. Ms B also stated that no staff members wore gloves while administering Mrs A's insulin or checking her BGL. Ms B said that she had seen the standard of infection control at the public hospital, and that Mrs A went from that to "nothing" at the RCU.

122. Ms B recalls being told by RN C that rest home staff did not need to wear gloves while administering insulin or checking BGL, and that this was the difference between a hospital and a rest home environment.

123. RN C told HDC: "Infection Control measures were put in place, equipment of gloves and aprons, handwashing notices and all standard precautions highlighted. I acknowledge that these measures at times were not followed as ordered." The rest home told HDC that it acknowledges that there was a missed opportunity for learning at that time.

Meetings with Ms B and subsequent events

First meeting — 2 February 2012

124. On 2 February 2012, Ms B (together with a consumer support person, Ms M) attended a meeting with RN C and General Manager Mr N[37] to discuss the level of care being provided to Mrs A. Meeting notes prepared by Ms M record that communication had broken down between Ms B and rest home staff. The notes further record that Ms B was frustrated that there had been recurring problems with "specialist recommendations" not being fully implemented into Mrs A's daily care.

125. In particular, the notes record that Ms B recounted her impressions and frustrations with the rest home's management of Mrs A's "diabetic episode" between 21 and 23

[36] For example, on 21 October 2011, 5 December 2011, and 22, 24 and 25 March 2012 Mrs A's progress notes record that she refused to wear her foam boots and/or asked that they be removed.
[37] Mr N has since resigned from his position at the rest home.

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December 2011. Ms B also raised concern with the use of dock leaf poultice instead of Aquacel, and the failure to implement Mrs A's physiotherapy regimen following her discharge from the private hospital.

126. The notes record that RN C explained "her 'legal duty of care' and how that affects her decision surrounding what is best for each patient. She does not blindly follow the recommendations but carefully assesses the whole situation medically." In an interview with HDC, RN C explained that Ms B wanted RCU staff to do exactly what was set by the specialists involved in Mrs A's care. RN C recalls that issues arose because Mrs A made her own decisions for her own reasons, and RN C considered those reasons to be valid.

127. The notes further record that there was discussion around the lack of variety in Mrs A's diabetic diet, and that Ms B had asked that Mrs A be moved into one of the new rooms within the RCU. Ms B told HDC that she also raised some concern regarding a caregiver's technique in administering insulin to Mrs A. Ms B stated that she had observed a caregiver "giving mum her insulin but injected it so quickly in and out that the insulin was still dripping onto the floor". Ms B cannot recall when this incident occurred. It was not recorded in the meeting minutes or Mrs A's clinical file.

128. The notes record that RN C agreed to be Ms B's point of contact at the RCU, and that she would attend 30-minute weekly meetings with Ms B to discuss Mrs A's care. In her interview, RN C explained that this was intended to provide consistency in Ms B's dealings with the rest home.

Fall — 12 February 2012

129. On 12 February 2012 at 4pm, Mrs A fell while walking unassisted and broke her right NOF. Ms B told HDC that Mrs A had been put in her chair at approximately 1pm on 12 February and remained there until 4pm with no access to a call bell or to her table with water, glasses, television remote and books. HDC asked Ms B how she knew that Mrs A had been left in her chair for three hours. Ms B stated that she "assumed with past history" that this is what would have happened.

130. Ms B stated that Mrs A would often be left unattended in the afternoons and would call out for assistance, but staff would not respond. Ms B also recalls that when she arrived at the RCU after the fall, she saw that the call bell had been wound up and put away, whereas it would usually be draped across the bed and slung over where Mrs A was sitting.

131. The rest home told HDC that Mrs A did have access to a call bell "as is evidenced in the progress notes". At 4.20pm, it was recorded in Mrs A's progress notes that she had fallen at 4pm. An entry was also made on a separate page of Mrs A's progress notes, which records that at 3pm, a caregiver had toileted Mrs A before sitting her back in her chair and putting the call bell within her reach. There are no other entries on that page of Mrs A's progress notes. The following page continues with an entry dated 12 February 2012 at 6pm.

132. The rest home stated that the call bell had been removed prior to staff assisting Mrs A to the dining room. The rest home told HDC:

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"Unfortunately the caregiver left the room for a few minutes before taking [Mrs A] to the dining room resulting in [Mrs A] not having the bell with her. [Mrs A], it appears, attempted to go to the toilet independently and fell, resulting in the fracture."

133. RN C told HDC that "[w]hat was critical to [Mrs A's] last fall and fracture was the shift at [Ms B's] request from a compact room in [one area] where she knew the handholds on the way to the toilet to a new and spacious room in the redevelopment". RN C explained that neither she, Ms B nor Mrs A anticipated the effect that this would have for Mrs A in terms of her moving around the room. RN C stated that it was disorientating for Mrs A, as the hand holds were not automatic and there was a greater area to cover.

134. Mrs A told HDC that she is unable to recall this incident.

135. At 5.10pm, Mrs A was transferred to the public hospital by ambulance. On 24 February 2012, Mrs A was assessed as requiring hospital-level care.

Second meeting — 28 February 2012

136. On 28 February 2012 (while Mrs A was in the public hospital), RN C attended a meeting with Ms B. Meeting notes record that they discussed a number of aspects of Mrs A's care, including:

- With regard to Mrs A's diabetic care plan, it was noted that ketones were being tested through blood and that Ms B would check with the Diabetic Clinic whether this was to be done when Mrs A's BGL exceeded 18mmol/L only or when she also exhibited symptoms of diabetic ketoacidosis.
- Infection control measures regarding personal cares had been put in place which required gloves to be worn by staff at all times.
- A physiotherapy and exercise plan had been put in place for Mrs A's recovery from her fall.

Restraint/Enabler Plan — 28 February 2012

137. Also on 28 February 2012, a Restraint/Enabler Plan was signed by RN C, Dr D, and Ms B as EPOA.[38] It provided for Mrs A's bed rails to be up while she was in bed, with two-hourly monitoring. The Restraint/Enabler Plan was not signed by Mrs A. At the time, Mrs A was still in the public hospital.

138. Ms B stated that the Restraint/Enabler Plan was signed in RN C's office, and that Mrs A was not present. Ms B recalls that RN C did not explain why she was asking Ms B rather than Mrs A to sign the Restraint/Enabler Plan, and there was no discussion around whether the EPOA should be activated. Ms B stated that she cannot specifically recall discussing the Restraint/Enabler Plan with Mrs A. Ms B subsequently told HDC that she would have discussed it with Mrs A, as she does not make decisions like that without letting her mother know.

[38] As stated, the EPOA had not been activated.

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139. RN C told HDC that she discussed the Restraint/Enabler Plan with Mrs A before it was signed, but did not document that conversation. RN C recalls that the conversation took place in the RCU lounge, and they discussed the need to use bed rails in order to keep Mrs A safe. RN C told HDC that she does not know whether Mrs A understood the conversation.

140. RN C stated that she cannot explain why she asked Ms B to sign the plan instead of Mrs A. RN C cannot recall any discussion between herself and Ms B as to whether Ms B had spoken to Mrs A about the Restraint/Enabler Plan. RN C noted that Ms B had been asking for restraint, and acknowledged that the Restraint/Enabler Plan should not have been signed by Ms B.

Short-term care plan — 28 February 2012

141. Also on 28 February 2012, a short-term care plan was documented to address Mrs A's care requirements arising from her fractured NOF. The plan recorded that Mrs A was to have two-person assistance at all times when mobilising, set out a series of exercises to be completed, and noted that a urine test was required following removal of Mrs A's catheter.

Mrs A's return to the RCU — 29 February 2012

142. On 29 February 2012, Mrs A was discharged from the public hospital and returned to the RCU. RN C was on leave, and RN I was acting RCU Manager in RN C's absence of one month.

143. In her complaint to HDC, Ms B stated that nothing changed between rest-home level and hospital-level care at the RCU. RN C stated that changes made to Mrs A's care plan were in relation to her mobility assistance.

144. On 2 March 2012, Mrs A's catheter was removed. The short-term care plan noted that a urine test was due to be done on 9 March 2012. This did not occur. In a letter dated 30 April 2012, Mr N noted, "[T]his was not done due to lack of communication between Registered Nurses."

145. On 9 March 2012, Mrs A was seen by a physiotherapist, who recorded in her progress notes that Mrs A had walked with the assistance of two people and was to continue walking regularly even if only for a few steps.

Third meeting — 13 March 2012

146. On 13 March 2012, RN I (in RN C's absence) attended a meeting with Ms B. The meeting notes record that various aspects of Mrs A's care were discussed, including:

- Ms B advised RN I that she had observed one caregiver transferring Mrs A and another caregiver tending to Mrs A without gloves. RN I noted that she had discussed this with the caregivers and registered nurses at handover.
- It was noted that Mrs A's BGL was "trending high at present". RN I recorded that she was to follow up on Mrs A's urine sample and implement a food diary in order to exclude urinary tract infection or diet-related reasons for Mrs A's

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elevated BGL. RN I noted that if these factors could be excluded, Ms B would like input from a diabetic nurse.

- RN I was to remind staff that if Mrs A had two BGL readings above 18mmol/L then she must have a ketone test.

147. On 13 March 2012, a food diary was commenced in which caregivers documented the date, time and details of Mrs A's meals and snacks. The food diary contains 13 entries between 13 and 29 March 2012 (when Mrs A was discharged from the RCU).

First complaint — 15 March 2012

148. On 15 March 2012, Ms B made a three-page written complaint to the rest home regarding "staff covering up and lying", in which she set out a number of concerns. In particular:

- Ms B was told by rest home staff that a urine sample had been taken for testing following the removal of Mrs A's catheter. On 15 March 2012, the medical centre advised Ms B that the laboratory had not received a sample.

- Ms B noted that she had discussed the parameters for ketone testing with RN C and RN I. On 15 March 2012, RN K advised Ms B that rest home staff were testing for ketones when Mrs A's BGL exceeded 18mmol/L and she showed symptoms of ketoacidosis. Ms B noted that she had contacted the Diabetic Clinic, which advised that ketone testing was to be done when Mrs A's BGL exceeded 18mmol/L (whether or not she was symptomatic of ketoacidosis) and asked that management put this into action. Ms B noted, "I really shouldn't have to check."

- Ms B reiterated her concern that she had observed only one person assisting Mrs A to mobilise. She also noted that Mrs A's foam boots had been removed and replaced with a pillow.

149. On 15 March 2012, Dr E, an endocrinologist, wrote to the rest home requesting that Mrs A's ketone levels be tested by blood or urine if her BGL exceeded 18mmol/L, or if she felt unwell.

150. On 17 March 2012, RN K responded in writing to Ms B's complaint of 15 March. RN K noted:

- Rest home staff had been unable to obtain a urine sample on 9 March 2012, as Mrs A was unable to pass urine on demand. A sample was obtained on 16 March 2012.

- Ketone testing was to be done if Mrs A's BGL exceeded 18mmol/L twice, and one symptom of ketoacidosis was present.

- Mrs A required two-person assistance to mobilise. RN K noted that "on a good day" Mrs A required one-person assistance, although she required a lifting belt at all times. RN K further recorded that when Mrs A was seen by the physiotherapist on 9 March 2012, she required two-person assistance but that this "change[d] each day".

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- Mrs A was to wear her foam boots while in bed and a pillow was not to be used.

151. In a letter dated 30 April 2012, Mr N recorded that on 17 March 2012, "the Registered Nurse in charge" had discussed Mrs A's mobility assistance needs with caregivers with the resulting instruction: "[O]ne assist to mobilise when [Mrs A] is aware and co-operative, two assist when non-compliant."

152. RN C explained that there was some leeway around Mrs A's mobility assistance needs in terms of when she required two-person assistance. RN C recalls that two people were usually required when Mrs A was tired or uncooperative. RN C explained that the caregivers knew Mrs A and made an assessment as to whether she was cooperative or not.

Second complaint — 20 March 2012

153. On 20 March 2012, Ms B made a further written complaint to the rest home in which she recorded a number of concerns regarding Mrs A's care. In particular:

- Ms B noted that the information recorded in Mrs A's food diary was not "true and correct" in that fruit salad and ice-cream given to Mrs A at lunchtime was not documented.
- Ms B noted that she had observed Mrs A sleeping without her foam boots on.
- Ms B requested a copy of the diabetic menu and noted that she believed that Mrs A was being given regular desserts.
- Ms B noted that she was "extremely concerned" by RN I's explanation that Mrs A received one-person assistance "on a good day". Ms B queried who gave the instruction for this amendment to Mrs A's care plan, as it was not Ms B, Mrs A or her physiotherapist or GP.

154. On 20 March 2012, RN I met with Ms B to discuss her complaint. The minutes record that they discussed each of the matters raised by Ms B in her complaint.

155. On 22 March 2012, RN K provided a written response to Ms B's complaint, which noted that Mrs A's care plans had been rewritten to ensure that caregivers were "aware of [Ms B's] wishes". RN K noted: "[Mrs A] does have some cognitive impairment which means at times she can't/won't walk for us, demands food she knows she shouldn't have and is unable to provide urine specimens when we need one."

Short-term care plan — 22 March 2012

156. On 22 March 2012, RN I documented a full-page short-term care plan for Mrs A, which recorded that she required two-person mobility assistance and use of a transfer belt, her cot sides were to be up and her foam boots on whenever she was in bed, her food and fluid chart was to be completed each shift, and her ketone levels were to be tested if her BGL exceeded 18mmol/L twice.

157. Also on 22 March 2012, a notice was issued to the caregivers, which recorded that Mrs A was to have access to her call bell when seated, cot sides up and foam boots on when in bed, two-person assistance with a transfer belt when mobilising, and that

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staff were to wear gloves when washing or toileting Mrs A. The notice recorded that gloves were not necessary when mobilising Mrs A.

158. Progress notes indicate that at 10pm on 22 March 2012, Mrs A rang for assistance as she was "unhappy" with her boots. The progress notes record that Mrs A "demanded them off as they were hurting her feet".

Third and fourth complaints — 22 March 2012

159. On 22 March 2012, Ms B made a third and fourth written complaint to the rest home. The third recorded that Ms B had observed Mrs A in bed without her foam boots and one person assisting Mrs A without a transfer belt. Ms B noted that she had taken a photograph of the person assisting Mrs A.[39]

160. The fourth complaint recorded a series of concerns with the care provided to Mrs A during the course of her time in the RCU, set out over two pages. The concerns included heel ulcer dressings not being changed every two days; a lack of variety in Mrs A's diet; Mrs A's diabetic diet not being followed; her BGL not being checked two hourly; Ms B "having to fight" to ensure that Mrs A's ketone levels were tested; Ms B not being informed of Mrs A's appointments with her physiotherapist, GP and diabetic nurse; Mrs A's physiotherapy plan not being followed after her discharge from the private hospital; and Mrs A's care plan being changed (including the use of dock leaf poultice and one-person mobility assistance).

161. On 23 March 2012, Mr N wrote to Ms B to arrange a meeting with her and a mediator on 3 April 2012 to discuss her complaints.

Fifth complaint — 23 March 2012

162. On 23 March 2012, Ms B made a fifth (two-page, written) complaint to the rest home. Ms B noted that she had taken a photograph of a caregiver administering insulin to Mrs A without gloves.[40] Ms B also noted that she had received a telephone call from RN K at 11.15am advising that Mrs A was having her annual assessment. Progress notes record that RN K "was informed yesterday that [the assessment] may happen today but neglected to inform [Ms B]".

163. Ms B recorded: "I have found this complaint process very frustrating. Mum has been left in an unsafe environment."

164. On 24 and 25 March 2012, progress notes record that Mrs A refused to wear her foam boots. The notes record that "it was pointed out to her that it was necessary. She then asked whose idea was it. We then referred to the instructions on her wall and that it was [Ms B's] request. She then said [Ms B] would not do or say anything like that."

Sixth complaint — 26 March 2012

165. On 26 March 2012, Ms B made a verbal complaint to RN I regarding caregiver Ms O attempting to mobilise Mrs A without the assistance of a second caregiver.

[39] The photograph was provided to HDC.
[40] The photograph was provided to HDC.

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166. Ms B documented that Ms O had assisted Mrs A to and from Ms B's car, and that "[s]he did not ask anyone else for help. I said please don't count me as 1 person helping cause I'm not qualified. No answer from her." Ms B noted that Mrs A needed to go to the toilet and that by the time they reached her room her pad was wet and needed changing. Ms B recorded that she then observed Ms O mobilising Mrs A without a lifting belt or a second caregiver. Ms B then asked RN I to come into the room.

167. RN I completed an adverse event form, which recorded that Ms O was attempting to move Mrs A onto the centre of her bed and up the bed by herself. RN I recorded that she asked Ms O if she needed assistance, which she accepted, and they moved Mrs A onto the bed together. The form records that RN I discussed the incident with Ms O, who advised that she allows Mrs A to try to move herself, but if she is unable to do so, Ms O calls for assistance. Ms O stated that she would have called for assistance had RN I not entered the room at that time. RN I reminded Ms O that Mrs A required two-person assistance at all times.

Fourth meeting — 27 March 2012

168. On 27 March 2012, RN I met with Ms B to discuss her complaint. Ms B advised that Mrs A was being transferred to another rest home.

Discharge to Rest Home 2

169. On 29 March 2012, Mrs A was discharged from the RCU and transferred to Rest Home 2. Rest Home 2 completed a two-page Transfer/Discharge Form, which set out Mrs A's medical history and independence levels. The first rest home told HDC that, "in the interests of clarity, our progress notes should have highlighted accurately what information was transferred with the resident". Ms B stated that the RCU provided inaccurate information to Rest Home 2 regarding Mrs A's insulin regimen.

170. On 30 March 2012, the RCU sent Mrs A's insulin regimen to Rest Home 2. The medication form erroneously recorded that Mrs A was to have 21 units of Lantus twice daily or as directed.[41] On 3 April 2012, the RCU sent an amended medication form, which provided for one dose of Lantus in the morning.

171. Ms B stated that the RCU also did not provide Rest Home 2 with Mrs A's ketone monitor or ketone testing regimen. Ms B submitted that, as a result, Mrs A was admitted to the Emergency Department at the public hospital on 29 June 2012 as Rest Home 2 staff were unable to test her ketone levels.

172. The rest home told HDC that its medication forms are generated at the pharmacy, sent to Dr D for signing, and then sent to the RCU. It advised that the instruction to give Lantus "as directed" is in part a pharmacy requirement to have a dose rate recorded. The rest home stated:

> "With ketone testing, this is part of caring for elderly diabetics. This can be tested via the urine with a test strip or using a blood testing monitor. I do not think for a moment that [Rest Home 2's] eight registered nurses would not know ketone

[41] Mrs A's insulin regimen called for 21 units of Lantus once daily.

HDC

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acidosis monitoring especially given [Mrs A's] history. [Mrs A's] trip to [the public hospital] three months after admission to [Rest Home 2] attributed to an inability of the staff to ketone test would seem to be inaccurate."

173. Mrs A continues to reside at Rest Home 2. In late 2013, Mrs A was reassessed as requiring rest-home level care.

Changes made by the rest home

174. The rest home told HDC that it has made a number of changes to relevant aspects of its practice as a result of these events. In particular:

- A number of new roles have been established and introduced within the rest home, including a Clinical Co-ordinator role (20 hours) and a new Education/Admission role. The rest home's General Manager has a clinical as well as management background.
- The RCU Manager has created Roster 5 in recognition of the increased complexity of new admissions to the RCU. Roster 5 involves a higher level of overview for complex residents. It was initially commenced with senior caregivers. Training is now being provided to less experienced caregivers. Liverpool Pathway Training is provided and there are monthly meetings with the Clinical Co-ordinator to discuss any areas of concern. The rest home advised that Mrs A would have been included in Roster 5 had this been in place during her residency.
- EDEN Alternative training is accessed by registered nurses and caregivers.[42] A lead EDEN group meets monthly to set programmes for resident care. In-service training is provided by these staff.
- A Leadership Forum has been commenced, the purpose of which is "to discuss any pending issues affecting service delivery and personnel; to make collective decisions and ultimately work as a collegial team with clear communication and direction. That as a Leadership team we would mitigate organisational risk and model the culture we expect at [the rest home]."
- A new physiotherapy contract has been introduced. A weekly schedule has been put in place with each resident to have an updated assessment. All new residents are assessed by the physiotherapist, who is also in attendance at meetings when requested.
- Food diaries have been implemented as a means to support the care of diabetic residents.
- The rest home undertook to update all policies and procedures. Documentation has also been reviewed and updated, including handover sheets and wound management forms. Documentation of falls is now done on a separate form from adverse event reporting, which is colour specific for increased visibility.

[42] EDEN Alternative is a philosophy of aged care promoted by an international non-profit organisation of the same name.

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- The rest home engaged a consultant to review policies, procedures and quality control management.
- Complaints procedures have been reviewed and included as an agenda item for Board meetings.
- The rest home has purchased new equipment including a second hoist to assist in transferring patients, two overhead hoists for bathing, and four electric mattresses. The rest home also advised that the purchase of new hospital beds is 80% complete.
- Two registered nurses have completed further InterRAI training.[43]

Response to provisional opinion

175. In its response to my provisional opinion, the rest home stated that it "reluctantly accepts" my findings. The rest home stated further that it is confident that with its current infrastructure "any deviations from the required standard of care results in immediate and appropriate action being taken and these actions are addressed fully with the individual/s concerned by the General Manager and Care Unit Manager".

176. RN C told HDC that she also accepts the findings set out in my provisional decision.

Relevant standards

177. The New Zealand Health and Disability Services (Core) Standards (NZS 8134.1.2.:2008) published by the Ministry of Health state:

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

[43] InterRAI is a collaborative network of researchers in over 30 countries committed to improving care for persons who are disabled or medically complex, and provides compatible assessment instrumentation that can be used across healthcare sectors.

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Family/whānau participation

Standard 2.6 Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

…

Consumer information management systems

Standard 2.9 Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required

…

Nutrition, Safe Food, and Fluid Management

Standard 3.13 A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery."

178. The Nursing Council of New Zealand Competencies for registered nurses scope of practice[44] provide:

Domain one: professional responsibility

- Competency 1.3: Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others.

Domain two: management of nursing care

- Competency 2.1: Provides planned nursing care to achieve identified outcomes.
- Competency 2.3: Ensures documentation is accurate and maintains confidentiality of information.
- Competency 2.3: Ensures the health consumer has adequate explanation of the effects, consequences and alternatives of proposed treatments.

Competencies for nurses involved in management

- Promotes a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.

Domain three: interpersonal relationships

- Competency 3.1: Practises nursing in a negotiated partnership with the health consumer when and where possible.

Domain four: interprofessional health care & quality improvement

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

[44] This document was first published by the Nursing Council of New Zealand (NCNZ) in December 2007 (available at www.nursingcouncil.org.nz).

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Opinion: Introduction

179. Mrs A was admitted into the RCU at the rest home in November 2010, having fractured her NOF the previous month. Mrs A remained in the RCU until March 2012, during which time there were numerous issues with the implementation of her care plan by rest home staff.

180. On 30 September 2010, Mrs A signed a document appointing Ms B as her EPOA in relation to personal care and welfare. Pursuant to section 98(3)(a) of the Protection of Personal Property Rights Act 1988 (PPPRA), an attorney must not act in respect of a significant matter relating to the donor's personal care and welfare unless a relevant health practitioner has certified that the donor is mentally incapable. A significant matter means a matter that is likely to have a significant effect on the health, well-being or enjoyment of life of the donor.[45] The rest home told HDC that Mrs A "was never clinically or legally assessed as being incapable of acting in her own best interest. A certificate of incapacity was never issued." Accordingly, the EPOA was never activated.

181. Mrs A was therefore entitled to make decisions about her own care and welfare. Pursuant to s93B(1)(b) of the PPPRA, there is a presumption of competency in respect of personal care and welfare until the contrary is shown. Right 7(2) of the Code also provides that every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent. Of particular significance in this matter is s93B(3) of the PPPRA, which provides that a person must not be presumed to lack competence simply because the person "makes or intends to make a decision in relation to his or her personal care and welfare that a person exercising ordinary prudence would not make in the same circumstances".

182. Health and Disability Sector Standards provide that family of choice are to be involved in the planning, implementation, and evaluation of services to ensure that they are responsive to the needs of individuals. Although Ms B was to be involved in Mrs A's care (as per her Personal Care Plan), Mrs A nonetheless retained the right to make decisions about her own care and welfare.

Opinion: RN C

Introduction

183. During Mrs A's residency in the RCU, RN C was the RCU Manager. RN C was on leave for the month of March 2012, during which time RN I was acting RCU Manager. I accept that RN C was not personally involved in the events that took place following Mrs A's return from the public hospital on 29 February 2012.

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[45] Section 98(6).

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184. My expert advisor, Ms Russell, advised me that, having reviewed RN C's conduct, "on most occasions the competencies and associated indicators are met". However, I consider that there were aspects of the care RN C provided to Mrs A that were suboptimal, particularly in regard to diabetes management, consultation with Mrs A, and communication with family.

Diabetes management — Breach

185. Mrs A's documented diabetic care plan provided for two-hourly monitoring of her BGL following the administration of a correction dose of insulin. It did not specify when Mrs A's ketone levels were to be tested.[46]

186. RN C told HDC that the requirement for two-hourly BGL monitoring "slipped through" as it does not form part of the ordinary clinical management of diabetes, and was not specifically brought to her attention by the diabetes service. I do not accept that responsibility lay with the diabetes service to specifically bring this requirement to RN C's attention. The requirement was documented in a number of care plans provided to the rest home by the diabetes service during Mrs A's residency in the RCU.

187. RN C's position description as RCU Manager records that she was responsible for (among other things) monitoring the evaluation of care plans and co-ordinating the registered nursing team (including maintaining daily oversight of the registered nurses). The requirement for two-hourly BGL monitoring was clearly documented in Mrs A's care plan, and yet BGL records indicate that this was not initiated as a matter of course following the administration of correction doses (although it did occur on occasion).

188. There was ongoing confusion as to when ketone testing was to occur. As noted by Ms Russell, "The question that requires answering is whose responsibility was it to manage this and ensure clarity regarding management. Ultimately it was RN C's role and responsibility as defined in her position description to ensure these things [were] done."

189. In my view, RN C breached Right 4(1) of the Code by failing to provide services to Mrs A with reasonable care and skill, in that she overlooked the requirement for two-hourly BGL monitoring and failed to clarify the requirements for ketone testing as part of Mrs A's diabetic care plan.

Consultation with Mrs A — Breach

190. With any health service, treatment should be provided only with the informed consent of the consumer. This is affirmed in Right 7(1) of the Code, which states that services can be provided to a consumer only if that consumer makes an informed choice and gives informed consent (unless another law, or any other provision of the Code provides otherwise). Pursuant to Right 6 of the Code, prior to making an informed choice and giving informed consent, a consumer needs to be fully informed about the services he or she is being asked to consent to. Right 6(1) of the Code states that

[46] As stated, Ms B and the DHB provided HDC with an undated ketone management plan for Mrs A, which was not included in [the rest home's] documentation.

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consumers have the right to receive information that a reasonable consumer, in that consumer's circumstances, would expect to receive about his or her care and treatment, including an explanation of his or her condition and the treatment options available. Patients are also entitled to receive an assessment of the expected risks, side effects, benefits and costs of each option. This is necessary in order for the patient to make an informed choice and/or provide informed consent to the treatment being offered.

191. In my view, RN C failed to meet these requirements with regard to both the treatment of Mrs A's heel ulcer and the development of Mrs A's Restraint/Enabler Plan dated 28 February 2012.

Wound-care management

192. During Mrs A's time in the RCU, she received treatment for her heel ulcer. The treatment plan provided by Mrs A's podiatrists called for the ulcer to be cleansed with saline and dressed with Aquacel and sterile gauze, and bandaged on alternate days. RN C told HDC that the rest home (in consultation with Dr D) often used a rotation of dock leaf poultice, Aquacel and manuka honey for wound care and management. Dr D confirmed that he did not object to the use of alternative therapies (unless there was an absolute contraindication).

193. Ms Russell advised:

> "The care plan was not written by [RN C] as this was not her role — however, it would be her role to ensure that there was a process in place to ensure it was an accurate reflection of [Mrs A's] requirements, her dressing was being done adequately …"

194. Ms Russell further advised:

> "A fundamental wound management practice is to ensure consistency in the dressing and whilst manuka honey is used in wound management I could find little on dock poultice and there was nothing apart from some anecdotal comment provided in the [the rest home] material regarding their possible benefit."

195. Mrs A's wound management record indicates that her heel ulcer was packed with dock leaf poultice on 27 and 30 April 2011. On 2 May 2011, podiatrist Ms H wrote to Dr D, recording that the dressing plan had not been followed and reiterating that Mrs A's heel ulcer was to be dressed with Aquacel. It was also noted in the progress notes that Ms B was "really upset" about the dressing plan not being followed. Mrs A's heel ulcer was again packed with dock leaf poultice on 27 May 2011. The ulcer was otherwise dressed with a rotation of Aquacel and manuka honey with tulle throughout her residency in the RCU. As Dr D explained, Mrs A's heel ulcer was treated with "long periods of regular, frequently changed conventional dressings" and a "short period of dock leaf poultices".

196. My primary concern is that it is unclear what communication, if any, took place between RN C and Mrs A regarding the use of dock leaf poultice instead of Aquacel.

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197. RN C explained that she would not have had a detailed conversation with Mrs A about why different dressings were being used, but that Mrs A would have been aware of what dressings were being used through general conversation. In contrast, Mrs A told HDC that rest home staff did not discuss the treatment of her ulcer with her. I agree with Ms Russell's comment that "it is unfortunate that these discussions were not substantiated in the notes when the poultice was used".

198. Ms B told HDC that she found out about the use of dock leaf poultice through a conversation with RN C after it had been commenced. Ms B recalls being told that the poultice was working well, and that she therefore went along with it. The rest home told HDC, "We acknowledge there was a discussion with [Ms B] during which [Ms B] expressed a view that alternative medications [were] not to be used. This should have been documented."

199. I do not consider that RN C met accepted standards in her dealings with Mrs A with regard to the treatment of her heel ulcer. In particular, it does not appear to me that sufficient steps were taken to ensure that Mrs A supported the use of dock leaf poultice as part of her care plan (as opposed to the care plan set by her podiatrists). It was not sufficient for RN C to assume that Mrs A would have been aware of what dressings were being used through general conversation. I am critical of RN C's failure to document any discussion with Mrs A with regard to this treatment, which, in my view, would have avoided significant confusion and tension between the rest home, Mrs A and Ms B.

Restraint/Enabler Plan

200. On 28 February 2012, a Restraint/Enabler Plan was signed by RN C, Dr D and Ms B as EPOA.[47] It provided for Mrs A's bed rails to be up while she was in bed, with two-hourly monitoring. It was not signed by Mrs A, who was still in the public hospital at the time.

201. RN C stated that she cannot explain why she asked Ms B to sign the Restraint/Enabler Plan instead of Mrs A, and acknowledged that it should not have been signed by Ms B. RN C further advised that she discussed the proposed restraint with Mrs A before it was signed but did not document that conversation. RN C does not know whether Mrs A understood the conversation.

202. Ms B stated that the Restraint/Enabler Plan was signed in RN C's office and that Mrs A was not present. Ms B recalls that RN C did not explain why she was asking Ms B to sign the Restraint/Enabler Plan rather than Mrs A, and there was no discussion around whether the EPOA should be activated.

203. It does not appear to me that adequate steps were taken to ensure that Mrs A was aware of, and supported, the proposed restraint. Although RN C recalls having discussed restraint informally with Mrs A, the documentation was signed in Mrs A's absence before she returned to the RCU from the public hospital. In my view, this failure to consult Mrs A appropriately in the development of this plan demonstrates a fundamental lack of understanding about her competency status. As noted by Ms

[47] As stated, the EPOA had not been activated.

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Russell, "This lack of understanding of this point appears to have substantially contributed to the ongoing concerns and the lack of resolution of them." Ms Russell further advised that RN C failed to meet expected standards with regard to "clarifying the communication channels and what needed to be communicated — this includes the treatment of Ms B as the next of kin and/or the EPOA". As RN C accepts, it was not appropriate for Ms B to sign the Restraint/Enabler Plan as EPOA in these circumstances.

Conclusion

204. I consider that RN C breached Right 6(1) and Right 7(1) of the Code with regard to both the treatment of Mrs A's heel ulcer and the use of restraint, in that she failed to provide Mrs A with information that a reasonable consumer in Mrs A's circumstances would expect to receive, with the result that Mrs A was unable to make an informed choice and give informed consent to those aspects of her treatment.

Communication with family — Adverse comment

205. Ms Russell advised me that RN C did not meet expected standards in terms of "not meeting the open disclosure requirements regarding the 'events — falls' that [Ms B] was not notified of". Although Mrs A's EPOA had not been activated, it was clear from her Personal Care Plan that Ms B was to be involved in Mrs A's care.

206. HDC asked RN C why Ms B was advised of some falls and not of others. RN C explained that most times Ms B would have been aware of adverse events, as staff would have seen her in the RCU and spoken to her about them (although it may not have been recorded). RN C acknowledged that there would have been some falls that Ms B did not know about.

207. I accept that there was most likely informal communication between RN C and Ms B regarding Mrs A's care that was not documented. It is evident that Ms B was closely involved in her mother's care and that, over time, the relationship between Ms B and RN C deteriorated. I accept that Ms B was frustrated with various issues that arose in relation to Mrs A's care, and that efforts were made by RN C to address these problems. I consider that the situation would have benefited from more thorough documentation of these communications.

208. I am critical of RN C's communication with Ms B regarding Mrs A's falls. While I do not consider that RN C has breached the Code in this regard, I nonetheless consider it suboptimal that RN C did not advise Ms B of some adverse events.

Opinion: The rest home

209. While I have identified concerns about the individual decision-making and actions of RN C, the rest home had a responsibility to operate in a manner that provided Mrs A with services of an appropriate standard. That responsibility comes from the organisational duty on rest home owners to provide a safe healthcare environment for

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residents. This duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It also includes responsibility for the actions of its staff.

210. As set out below, I consider that the rest home's care planning for Mrs A was appropriate in the circumstances. However, I have concerns with the implementation of that care plan, and with the rest home's documentation practices.

Care planning — No breach

211. On the day of Mrs A's admission to the RCU (1 November 2010), RN J completed an Initial Care Plan for Mrs A. On 8 November 2010, a Personal Care Plan was documented. The rest home's care-planning policy called for three-monthly reviews of Personal Care Plans. Mrs A's Personal Care Plan was reviewed four times during her residency. From December 2011, a series of short-term care plans were then documented for Mrs A.

212. Ms Russell advised me that "[t]he initial assessment undertaken at the time of admission to the [rest home] in 2010 was comprehensive and holistic, the evaluations were done three monthly which exceeds sector standards requirements for rest-home care at the time". I am satisfied that the services provided by the rest home were appropriate in this regard.

Implementation of Mrs A's care plan — Breach

213. Mrs A had a complex care plan that included input from various external providers. In my view, there were a number of issues with the implementation of Mrs A's care plan throughout her residency in the RCU.

214. The New Zealand Health and Disability Sector Standards (see above) require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely, appropriate, and safe services to consumers. Mrs A had a right to expect that the rest home and its staff would provide her with services of an appropriate standard and in accordance with her documented care plan. I consider that certain aspects of the care provided to Mrs A between November 2010 and March 2012 did not meet this standard.

Diabetic care plan

215. Mrs A's diabetic care involved regular insulin doses throughout the day, together with BGL checks before each meal, at 2am, and two hourly after any correction dose of insulin had been given. I am concerned that there was a lack of clarity amongst rest home staff as to the implementation of this plan with regard to her BGL monitoring and ketone testing.

216. The rest home accepts that the requirement for two-hourly BGL monitoring following a correction dose was "not consistently followed". BGL records confirm that two-hourly monitoring of Mrs A was not initiated as a matter of course following the administration of correction doses, although it did occur on occasion.

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217. Ms Russell advised: "If correction doses were charted to be given in response to a blood sugar level after insulin had already been given then at least two hourly blood sugars would be an expectation. This was not done but continued to be recorded as part of the action plan."

218. Mrs A's documented diabetic care plan also did not specify when Mrs A's ketone levels were to be tested. There was ongoing confusion between Ms B and the rest home as to when this testing was to occur. As noted by Ms Russell, the requirement for ketone testing was "not on the typed instructions for [Mrs A's] diabetic management and it is apparent in reading the associated material that the plan for doing this was unclear". Ms Russell further noted that although it was RN C's responsibility as RCU Manager to ensure that these aspects of Mrs A's care plan were performed, "it is in the RN competencies that all Nurses are responsible for ensuring adequate care and attention is paid to this".

219. I am particularly concerned that it was not until March 2012, following a complaint from Ms B, that the requirements for ketone testing were clarified with Dr E. This was approximately 15 months after Mrs A had been admitted into the RCU. Although it appears from Mrs A's progress notes and BGL record that ketone testing did occur intermittently during her residency, I agree with Ms Russell's comment that the overall plan in this regard appears to have been unclear and does not appear to have been well communicated amongst staff. I accept that this was frustrating for Ms B and agree with her comment that she "really shouldn't have to check". I would have expected the rest home to take proactive steps to clarify this aspect of Mrs A's care with Dr E, and I consider the failure to do so in a timely manner to be suboptimal in the circumstances.

Food diary

220. On 13 February 2012, a food diary was implemented for Mrs A, the purpose of which was to assess possible dietary causes for Mrs A's elevated BGL. However, the information recorded by staff was incomplete and inaccurate.

221. Ms Russell advised:

> "Given the need for this information to contribute to [Mrs A's] better health and its inception was the result of a complaint, it would be reasonable for the Manager and the RNs to have been involved in monitoring the completion of the food diary, to ensure it was completed correctly. It does not appear that this happened as there is lack of reporting noted in the food diary. No doubt, this contributed to the lack of trust that [Ms B] was already experiencing."

Urine test

222. Mrs A's short-term care plan dated 28 February 2012 recorded that a urine test was to be completed on 9 March 2012, following removal of her catheter on 2 March 2012. This did not occur and, on 15 March 2012, Ms B made a written complaint to the rest home. On 17 March 2012, RN K responded to Ms B's complaint, noting that staff had been unable to obtain a urine sample on 9 March 2012 because Mrs A had been unable to pass urine on demand. A urine sample was obtained on 16 March 2012.

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223. Ms Russell advised that incontinence "complicates the ease of obtaining urine samples. Whilst this may be complicated it is not impossible." I am concerned that rest home staff did not follow up on this aspect of Mrs A's care until after Ms B's complaint. As Mr N subsequently advised, the test "was not done due to lack of communication between Registered Nurses". I consider the failure to obtain a urine sample in accordance with Mrs A's care plan was suboptimal in the circumstances.

Mobility assistance

224. Mrs A required mobility assistance throughout her residency in the RCU. When she returned from the public hospital after breaking her right NOF, she had been assessed as requiring hospital-level care. She had previously fallen 15 times while in the RCU and, by February 2012, she had fractured both her right and left NOF as a result of falls. Understandably, Ms B was concerned to ensure that Mrs A received appropriate mobility assistance when she returned to the RCU.

225. On 28 February 2012, a short-term care plan was documented to address Mrs A's care requirements arising from her fractured NOF. The plan recorded that Mrs A was to have two-person assistance at all times when mobilising. Despite this plan, Ms B then observed a single caregiver assisting Mrs A to mobilise.

226. Ms B raised this incident in a meeting with RN I and in a complaint to the rest home. RN I explained that Mrs A's mobility assistance needs changed "each day" and that, "on a good day", she required the assistance of only one person. As Mr N later explained to Ms B, the registered nurse in charge had instructed the caregivers: "[O]ne assist to mobilise when [Mrs A] is aware and co-operative, two assist when non-compliant."

227. On 20 March 2012, Ms B made a written complaint to the rest home, which recorded that she was "extremely concerned" by RN I's explanation of her mother's mobility assistance needs. I am also concerned by this explanation.

228. It is evident that this was an ongoing issue following Mrs A's return to the RCU. Despite having specifically raised this issue with the rest home, on 26 March 2012 Ms B again observed a caregiver mobilising Mrs A without the assistance of a second caregiver. An adverse event form was completed, which recorded that the caregiver allowed Mrs A to attempt to mobilise herself, but that if she was unable to do so, the caregiver would then call for assistance. This is contrary to Mrs A's documented care plan. It is evident that this was not a single, one-off incident but rather part of a pattern of suboptimal conduct amongst rest home staff with regard to Mrs A's mobility assistance needs.

Physiotherapy

229. On 22 November 2011, Mrs A was admitted to the private hospital for surgery to remove a rod from her left hip (which had been inserted when she fractured her NOF in September 2010). Mrs A returned to the RCU on 29 November 2011. In her complaint to HDC, Ms B stated that RCU staff failed to implement Mrs A's physiotherapy regimen for two weeks following her discharge from the private hospital.

HDC

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230. Mrs A was seen by a physiotherapist on 30 November 2011. Between 1 and 9 December 2011, progress notes indicate that Mrs A was walking short distances, with no reference to exercises having been completed.

231. RN C told HDC that her recollection was that this issue had been raised in relation to Mrs A's rehabilitation following her release from the public hospital after her second fractured NOF on 12 February 2012, and not in relation to her rehabilitation following her release from the private hospital in November 2011. However, notes taken of a meeting held on 2 February 2012 between RN C and Ms B record that RN C "acknowledge[d] the caregivers did not put the exercise plan in place for two weeks. Exercise plan now in place."

232. The documentation surrounding this issue is unclear. The physiotherapist's entry in Mrs A's progress notes makes no reference to specific exercises. It records that Mrs A was to walk regularly (which she did). By 10 December, Mrs A's exercises were recorded as being done regularly. There is no documentation in Mrs A's records as to what these exercises involved or how this was communicated to rest home staff.

233. It appears that there was a period of 10 days between 30 November and 9 December 2011 in which exercises were not done. As stated, I accept that Mrs A was regularly assisted to walk during this time, as directed by the physiotherapist. Due to the paucity of documentation, it is unclear what exercises were supposed to be done as part of Mrs A's care plan. That said, RN C has acknowledged that the caregivers did not implement the exercise plan during this time. I consider the lack of clarity in the rest home's records with regard to this point to be suboptimal. This aspect of Mrs A's care plan was clearly a source of confusion.

Infection control

234. Ms B stated that she and Mrs A were concerned by the lack of infection control measures at the RCU. Ms B stated that rest home staff did not wash their hands before carrying out Mrs A's cares, and provided HDC with a photograph of a caregiver administering insulin without gloves.

235. Ms B told HDC that she had seen the standard of infection control at the public hospital, and that Mrs A went from that to "nothing" at the RCU. Ms B recalls being told by RN C that rest home staff did not need to wear gloves while administering insulin or checking BGL, and that this was the difference between a hospital and a rest-home environment. I note Ms Russell's comment that the management of ESBL positive patients "in a long term care facility is different to that in a public hospital". As stated, Ms Russell advised me that the level of care provided to Mrs A at the rest home was consistent with rest-home and then hospital-level care.

236. Mrs A's Personal Care Plan (dated 8 November 2010) provided that caregivers were to wear gloves while doing Mrs A's cares. The plan did not specify whether this included when administering insulin. On 28 February 2012, RN C met with Ms B to discuss Mrs A's care, and recorded in the meeting notes that infection control measures had been set in place, which required gloves to be worn at all times. This requirement was not recorded in Mrs A's short-term care plan of 28 February 2012.

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On 22 March 2012, a further short-term care plan was put in place, which recorded that staff were to wear gloves when washing or toileting Mrs A.

237. In my view, there was a lack of clarity in terms of what infection control measures were required as part of Mrs A's care plan, and that this in turn led to confusion amongst staff and tension between the rest home and Ms B.

Conclusion

238. I have concerns with the implementation of various aspects of Mrs A's care plan by rest home staff. It is evident that there were recurrent issues with a number of aspects of Mrs A's care plan being carried out in a consistent manner. Taken together, these failings indicate that there was a pattern of suboptimal conduct amongst rest home staff in this regard.

239. As this Office has stated previously, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that does not support and assist staff sufficiently to do what is required of them.[48] The rest home had a responsibility to ensure that its staff provided services of an appropriate standard.

240. In my view, the rest home breached Right 4(1) of the Code by failing to provide services to Mrs A with reasonable care and skill, in that various staff members failed to implement aspects of her care plan appropriately, including in relation to her diabetes management, mobility assistance, and infection control. In particular, rest home staff failed to:

- initiate two-hourly monitoring of Mrs A's BGL following the administration of correction doses of insulin, as set out in her diabetic care plan;
- clarify the requirements for ketone testing in a timely and proactive manner;
- ensure that the information recorded in Mrs A's food diary was accurate;
- perform a urine test on 9 March 2012, as set out in Mrs A's short-term care plan;
- provide mobility assistance to Mrs A in accordance with her short-term care plans dated 28 February and 22 March 2012 respectively;
- implement Mrs A's physiotherapy exercise plan between 30 November and 9 December 2011; and
- implement infection control measures in a clear and consistent manner.

Documentation — Breach

Frequency of dressings

241. The management of Mrs A's heel ulcer was recorded by various rest home staff in a series of different forms. Between 2 November 2010 and 2 May 2011, 15 of the entries in Mrs A's notes are more than three days apart (during which time her care plan required dressings to be done every two to three days). Between 4 May and 17 August 2011, seven of the entries made in Mrs A's notes are more than one full day

[48] Opinion 10HDC00308 (29 June 2012).

HDC

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apart (during which time her care plan required dressings to be done on alternate days).

242. RN C told HDC that this was "more a problem of non-recording than not being done". RN C submitted that the end result (that is, the healing of the ulcer) shows that the dressings were done.

243. I note Ms Russell's comment that "[o]ne of the difficulties is interpreting the various charts used for wound management and the way they are used". In my view, it would have been preferable to have a single record of the management of Mrs A's heel ulcer. I am also concerned that there is no record of what dressings were used between 4 and 25 May 2011. I am unable to make a finding as to whether Mrs A's heel ulcer was not dressed on alternate days or whether this was simply not recorded (as submitted by RN C). I am aware that by August 2011, Mrs A's heel ulcer had healed.

244. In any event, I do not consider it satisfactory for this information simply not to have been recorded. The importance of good record-keeping cannot be overstated. Accurate documentation is the basis for delivering continuous and appropriate care. The frequency of Mrs A's dressing changes is important clinical information relating to the treatment of her heel ulcer. In these circumstances, I would expect rest home staff to be meticulous with their recording of Mrs A's dressings.

Mrs A's non-compliance

245. Ms Russell advised me that one of the key factors in this case is "the difficulty when residents such as [Mrs A] are going against what would be best practice and the importance of documenting this and talking to families in order to seek the best outcomes for non-compliant residents". As Ms Russell further noted, "if instructions are not followed then this must be recorded in the progress notes with what was done recorded".

246. Part of the management plan for Mrs A's heel ulcer was for her to wear foam boots while in bed, which are designed to ensure that there is no pressure on the area. On a number of occasions Ms B observed Mrs A in bed without her foam boots. Ms B also told HDC that the caregivers did not know how to fit the boots correctly, and that she would sometimes find that the boots had twisted on Mrs A's feet. RN C told HDC that it was obvious how to use the boots, and that there was only one way to put them on.

247. I am unable to make a finding as to whether Mrs A's foam boots were being fitted correctly by rest home staff. However, I agree with Ms Russell's comment that "[c]ompliance seems to have been an issue for [Mrs A]". Progress notes indicate that Mrs A refused to wear her foam boots on occasion. As noted by RN C, this was an "ongoing issue". Ultimately, it was for Mrs A to decide whether she would wear her boots or not. In my view, more thorough documentation of Mrs A's decision-making throughout her residency in the RCU would have been appropriate.

248. Similarly, Mrs A had 15 falls between 3 November 2010 and 21 September 2011, nine of which occurred after she had apparently attempted to walk unassisted. Mrs A

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told HDC that she would "always" try to walk around, and said, "I like to be independent but I'm not."

249. It is evident that steps were taken to monitor and manage Mrs A's mobility. Mrs A was given a bell to ring for assistance, which she was encouraged to use. Progress notes indicate that on occasion Mrs A would attempt to mobilise without having rung her bell. Nursing staff and Ms B spoke with Mrs A about walking unassisted. As RN J recorded, "I have spoken with [Mrs A] about walking alone but she forgets."

250. On 19 November 2010, RN C and Ms B discussed Mrs A's falls management. RN C recorded that Ms B had asked that Mrs A be "restrained with bedrails and lapbelt when in wheelchair". RN C had concerns that Mrs A was "too aware" and would undo the lapbelt and climb over bed rails. Ms Russell advised me that RN C's discussion with Ms B was "grounded in good sense". It was agreed that restraint would be withheld. However, Ms Russell noted:

> "[T]he reasons for [Mrs A] not complying with requests not to mobilise and the potential for her to remove any form of restraint, as she was confused and did not always have good insight into her situation is neither well-documented nor included in her personal care plan. I believe this has contributed to the substance of this complaint."

251. I agree with Ms Russell's comments. While I accept that steps were taken to monitor Mrs A's mobility, the number of falls is significant and, in my view, there should have been more thorough documentation of Mrs A's compliance (or lack thereof) with her mobility regimen.

Conclusion

252. New Zealand Disability Sector Standards (see above) require that information is accurately recorded, current, and accessible when required. In my view, the rest home breached Right 4(2) of the Code by failing to provide services to Mrs A in accordance with legal standards, in that its documentation was suboptimal with regard to both the frequency of Mrs A's dressings and details of her non-compliance with aspects of her care plan.

Documentation of BGL — Adverse comment

253. I also have some concerns about the documentation of Mrs A's BGL. I note that there are some occasions when Mrs A's BGL was recorded in her progress notes but not in her BGL record. As noted by Ms Russell, "This is not helpful when it is the recording sheet that would be used for review by the General Practitioner or Diabetic Nurse Specialist." I note that overall rest home staff kept detailed recordings of Mrs A's BGL, but I consider it suboptimal that the documentation was not always on the correct form. While I do not consider that the rest home has breached the Code in this regard, I nonetheless recommend that the rest home reflect on this aspect of its practice.

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Other comment

Transfer to Rest Home 2

254. On 29 March 2012, Mrs A was discharged from the RCU and transferred to Rest Home 2. I note Ms Russell's preliminary comment that "[g]iven the complexity of [Mrs A's] care issues it would be expected that a transfer letter would be provided and possibly some sort of verbal handover". This information appears to have been provided by way of a two-page Discharge/Transfer Form, which sets out Mrs A's medical history and independence level.

255. Ms B told HDC that the rest home provided inaccurate information to Rest Home 2 regarding Mrs A's insulin regimen. On 30 March 2012, the rest home sent Mrs A's insulin regimen to Rest Home 2. The medication form erroneously recorded that Mrs A was to have 21 units of Lantus twice daily or as directed.[49] The rest home told HDC that its medication forms are generated at the pharmacy, sent to Dr D for signing, and then sent to the RCU. The rest home advised that the instruction to give Lantus "as directed" is in part a pharmacy requirement to have a dose rate recorded. This explanation does not address the inaccurate reference to Lantus being provided twice daily (rather than once daily).

256. On 3 April 2012, the rest home sent an amended medication form, which provided for one dose of Lantus in the morning. While I consider that this error in Mrs A's medication form was suboptimal, I also note that the form was not generated by the rest home and, in any event, the error was addressed promptly by the rest home.

257. Ms B stated that the RCU also did not provide Rest Home 2 with Mrs A's ketone monitor, or ketone testing regimen. Ms B submitted that, as a result, Mrs A was admitted to the Emergency Department at the public hospital on 29 June 2012, as staff were unable to test her ketone levels. The rest home stated that ketone testing is part of caring for elderly patients with diabetes, and can be done by urine as well as blood testing. For the purposes of this report, I am unable to comment on the care provided to Mrs A at Rest Home 2 or the reasons for her admission to the public hospital on 29 June 2012.

Diabetic diet

258. Ms B told HDC that she spoke to RN C "ten plus times" about the lack of variety in Mrs A's diabetic diet. Ms B was also concerned that Mrs A was given non-diabetic food by rest home staff. It appears from Mrs A's progress notes that this occurred both as a result of Mrs A being given non-diabetic food by staff, and Mrs A taking non-diabetic food of her own accord.

259. I note Ms Russell's comment that "[t]his is a difficulty in all resthome and hospital care as the staff strive to have a home like environment and of course one of the things about home is having the things you enjoy". While I consider that rest home staff had a responsibility to monitor Mrs A's diet, as stated, Mrs A was competent to make her own choices.

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[49] Mrs A's insulin regimen called for 21 units of Lantus once daily.

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Insulin administration

260. Ms B told HDC that in a meeting with RN C on 2 February 2012 she raised concern about a caregiver's technique in administering insulin to Mrs A. Ms B stated that she had observed a caregiver "giving mum her insulin but injected it so quickly in and out that the insulin was still dripping onto the floor". Ms B cannot recall when the incident occurred. It was not recorded in the meeting minutes or Mrs A's clinical file. I do not consider that currently I have, or can obtain, sufficient information to take this matter further.

Fall on 12 February 2012

261. On 12 February 2012 at 4pm, Mrs A fell while walking unassisted and broke her right NOF. Ms B stated that Mrs A had been left in her chair for three hours with no access to a call bell or to her table with water, glasses, television remote and books. The rest home told HDC that Mrs A did have access to a call bell that afternoon "as is evidenced in the progress notes".

262. It is accepted that Mrs A did not have access to her call bell at the time of her fall. The rest home stated that the call bell had been removed prior to staff assisting Mrs A to the dining room. The rest home submitted that Mrs A was left without access to her call bell for a few minutes. Ms B told HDC that when she arrived at the RCU, she saw that the call bell had been wound up and put away.

263. I am unable to make a finding as to how long Mrs A had been left without access to her call bell. Ms B told HDC that she "assumed with past history" what would have happened. However, Ms B was not at the RCU that afternoon, and Mrs A cannot recall the incident. An entry in the progress notes records that at 3pm, a caregiver placed Mrs A's call bell within her reach. I note that this entry was made on a separate page of Mrs A's progress notes. There are no other entries on that page. The preceding entry was made at 4pm (recording Mrs A's fall), and the next entry on the following page was made at 6pm. In the circumstances, I do not consider that the progress notes are determinative of this point.

264. I do not consider that I currently have, or can obtain, sufficient information to determine which account of events is accurate on this point. This does not mean that I have preferred one account over the other. It simply means that I do not have sufficient evidence to resolve the factual discrepancies or to take the matter further.

Management of urinary tract infection

265. Between 21 and 23 December 2011, Mrs A was receiving antibiotics for a urinary tract infection. Her BGL was elevated and progress notes indicate that she was nauseous and clammy. Ms B told HDC that she recalls asking rest home staff every day from 21 December 2011 for Mrs A to be taken to the public hospital. Progress notes indicate that Ms B did raise this on a number of occasions between 21 and 23 December.

266. On 21 December, Dr D commented that Mrs A was "OK to be transferred to hospital if family wishes". Mrs A remained in the RCU, where she was noted to be feeling "much better", and her BGL continued to be monitored. On 22 December, Dr D visited Mrs A and noted that her condition was improving. RN C contacted the

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Diabetic Clinic and was advised to continue monitoring Mrs A. That evening, RN C had a "very angry, abus[ive] phone call" with Ms B regarding Mrs A's care. Ms B recalls asking for Mrs A to be transferred to hospital and being told by RN C that staff were monitoring Mrs A and that Dr D did not think that Mrs A needed to go to hospital.

267. RN C told HDC that by 23 December, Mrs A was recovering well. Progress notes indicate that her BGL remained within "normal ranges" overnight and she was up for breakfast. That afternoon, Ms B arrived at the RCU and told staff that she was taking Mrs A to hospital. The rest home told HDC: "It was felt, based on our observations, the presentation did not warrant urgent transfer to hospital." Ms B then called an ambulance and Mrs A was taken to the public hospital. She was discharged back to the RCU later that night with no acute problems requiring admission.

268. Ms Russell advised me that "this episode appears to have been well and appropriately managed by the [rest home] Staff with input and support from [Dr D]". I note that Mrs A's BGL was closely monitored during this time and I accept the rest home's comment that its staff did not consider that a transfer to hospital was clinically indicated in the circumstances. I also accept that efforts were made to discuss this with Ms B.

Hospital-level care

269. On 24 February 2012, Mrs A was assessed as requiring hospital-level care. Before Mrs A was discharged from the public hospital, a short-term care plan dated 28 February 2012 was prepared to address her care requirements arising from her fractured NOF. Mrs A was discharged to the RCU the following day. In her complaint to HDC, Ms B stated that nothing changed between rest-home level and hospital-level care at the RCU.

270. Ms Russell advised me that the services provided to Mrs A at the RCU from November 2010 were consistent with rest-home level care. Ms Russell further advised that "[w]hilst there were a number of aspects of [Mrs A's] care that are not well recorded the level of care [Mrs A] required and was provided [from 24 February 2012] was consistent with hospital level care". I am satisfied that the services provided by the rest home were appropriate in this regard.

Recommendations

271. In my provisional report, I recommended that the rest home and RN C apologise to Mrs A and her family for their respective breaches of the Code. Written apologies have since been sent to this Office and forwarded to Mrs A's family.

272. I also recommended that relevant rest home personnel meet with Ms B to discuss Mrs A's care and subsequent changes made to the rest home's practice as a result of these events, and report the outcome of that meeting to HDC. Rest home staff have since

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met with Ms B and Mrs A, and the rest home has reported the outcome of that meeting to HDC.

273. The rest home has agreed to undertake an audit of the effectiveness of the changes made since this incident. I recommend that the rest home report the findings of that audit to HDC within three months of this report being issued.

Follow-up actions

274.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of the name of the rest home.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name and the name of the rest home.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Ministry of Health (HealthCERT), and it will be advised of the name of the rest home.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Deputy Commissioner

The following expert advice was obtained from Ms Julia Russell:

"6 June 2013

Report: [Mrs A], C12 HDC00915

Background

Thank you for requesting my review of [Mrs A's] file following the complaints made by [Ms B] — her daughter and enduring power of attorney. The purpose of this review is to provide a view as to whether the complaints are a mild, moderate or serious departure from the standards [Mrs A] and her family should expect.

[Mrs A] has a significant medical history which includes:

- Type 2 diabetes requiring insulin. This appears to be particularly unstable complicated by non-compliance related to a level of confusion. A degree of confusion is noted throughout the file, however there does not seem to be an identified reason for this but it is possibly related to other health issues
- Peripheral vascular disease leading to leg ulcers which required significant attention over a period of time
- ESBL positive (in 9/10)
- CABG, HTN and DKA in '09

[Mrs A] went to live in an independent unit at [the rest home] in April 2010. At this time, the care unit staff supported [Mrs A] in management of her insulin. In June and July 2010, [RN C] communicated to [Dr P] ([Mrs A's] then General Practitioner) and [the] Diabetes SL that [the rest home] felt [Mrs A] was unsafe and the staff at [the rest home] were not able to provide the level of support around her diabetic management they felt she required. [Mrs A] is described in [RN C's] 2010 letter to [Dr P] and [the Diabetes SL] and at the Public Hospital as sometimes confused and non-compliant. Nowhere in this complaint is [Mrs A] identified as incompetent in contributing or making her own health decisions — despite this [Mrs A's] view is neither sought or recorded regarding aspects of her care.

In September 2010, following a fall [Mrs A] broke her left hip. Following this it was identified she required a higher level of care and moved into resthome care at [the rest home]. [Mrs A] had further surgery to her left femur in November 2011 to remove metal work and post operatively it was identified that she required 2–3 people to transfer and at this time it was noted she was non-compliant with her exercises.

In February 2012, [Mrs A] had a further fall and fractured her right neck of femur and was returned to [the rest home] requiring hospital level care due to her increased dependency. This required a further assessment by [the District Health

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Board] which was planned for February and [Ms B] was not made aware of the timing of this.

In September 2011, [RN C] writes that there appeared to be communication issues from the outset with [Ms B] and identifies a discussion she had with [Ms B] about working together for [Mrs A's] benefit. [Ms B] herself notes that she went to [RN C] about numerous issues before she started formally recording them. In January of 2012, [Ms B] had sought the advice of [Ms M], Health and Disability Advocate to assist her in formally addressing her complaints and in February 2012 weekly meetings began with [the rest home] staff and [Ms B] to assist in resolving issues; these meetings occurred.

The complaints that [Ms B] has presented here span a number of issues and a considerable period of time and particularly focus around communication regarding aspects of [Mrs A's] health, management of leg ulcers, diabetic management and mobility issues following surgery and a further fall that led to the fracture of her right neck of femur in February 2012. It is important to note that the complaints raised by [Ms B] in this report do not cover all of the things she has complained about. The other complaints can be seen in the notes of meetings particularly those of [Ms M] and the weekly meetings with [the rest home] staff, many of which were resolved. A commitment to attending weekly family meetings to discuss issues is a large commitment both by [the rest home] and its staff but also by [Ms B] and all should be commended for their commitment to this. The following is a summary of the complaints addressed in this report and an indication of when they occurred.

A diabetic menu wasn't followed	On going
Complaints were not dealt with in a timely manner — [the rest home] policy says 14 days whereas HDC says 10 days.	On going
The monitoring of the post correction blood sugars did not occur	On going
Two staff members who had dealt with [Mrs A] inappropriately were not disciplined as [Ms B] had expected.	This occurred regarding two incidents
Resthome audits did not deal with the issues [Ms B] identified in her complaints.	Audit occurred on 11/11
[Ms B] doesn't believe that [Mrs A] was provided with the level of care — rest home and then hospital as she was assessed, believing that [the rest home] were getter extra funding for her care but not providing the expected level of service.	Throughout her time at [the rest home]
[Mrs A] fell 15 times in 15 months and her restraint/enabler assessment was not followed.	Throughout [Mrs A's] time at [the

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	rest home]
Of 20 adverse events [Ms B] was advised of 5.	
Podiatrist management for the heel wound was not followed — a herbal poultice was used.	2010/11
Physiotherapy plan for post surgical removal of the rod in [Mrs A's] leg not followed.	11/11
Following a diabetic incident [Mrs A] was not transferred to hospital.	15…/12/11
Inadequate handwashing techniques as [Mrs A] had been ESBL positive and had been MRSA positive.	Identified as ESBL+2010, c/o in 2012
No accessible bell resulting in a fall.	2/12
[Mrs A's] foam boots were not always put on.	Ongoing Feb 2012
Pillow under her legs.	
A urine sample that should have been taken March post catheter removal was not taken until 15/3/12.	3/12
A transfer belt was a requirement for [Mrs A's] care but not always used. This was in the care plan and been memoed to staff and an assurance to family that this would be a requirement of all staff.	Various times including 27/3
[The rest home] did not provide [Rest Home 2] the diabetic protocol for [Mrs A] upon her transfer to [the new facility].	29/3/12

The complaints:

1. [Ms B] doesn't believe that [Mrs A] was provided with the level of care — resthome and then hospital as she was assessed
   a. [Ms B] was not present at the reassessment for [Mrs A] in February 2012 — as she was not notified of it. Despite not attending the appointment [Ms B] concurs with the increased need and the move to hospital care for [Mrs A]. What she is asking for is that the extra money provided for increased care was demonstrated.

      In considering this it is imperative to remember the care plan and associated progress notes and the concerns identified by [Ms B] are all that can provide information about what the level of care provided was. [Mrs A] returned to [the rest home] after her February 2012 hospitalisation — her level of care and dependency had increased.

      A new short-term care plan written on 22/3/12 which included formal recognition of earlier issues — the risk of deep vein thrombosis (DVT) and pressure areas, bed rails were to be up when in bed and the foam boots were to be on. There were memos to staff regarding [Mrs A's]

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management. If the care givers were taking these actions when [Ms B] was there then it can be reasonably presumed that they cared for [Mrs A] that way all the time and this did not meet her assessment and documented care requirements.

There are comments in the notes from various [rest home] Registered Nurses/Manager that [Mrs A's] abilities varied from being able to walk to not being able to do this. The care staff should have been asked to report on [Mrs A's] mobility in her progress notes — this documentation would have supported what the RNs were saying and provide information about this to [Ms B]. Comments in her progress notes regarding her ability are infrequent and it would be helpful to remember this level of documentation for the future.

If there was a physiotherapist at [the rest home] regularly then a full assessment and ongoing evaluation of [Mrs A's] mobility should have been undertaken. If [the rest home] did not have a regular physiotherapist this injury would be covered by ACC and as such an assessment of her mobility could have been undertaken with minimal cost. Given the concerns that [Ms B] had raised regarding her mother's care in respect of mobility this would have been a sensible and reasonable expectation.

[…] [T]here is probably information that doesn't get recorded but is passed on by word of mouth. However, as we know if it is not written down then we cannot presume it has happened. It is important to remember in all aspects of [Ms B's] complaint the importance of paying attention to documentation as part of ensuring that care is provided.

This is a serious departure from the standards that a Resident and their family should be able to expect.

2. When giving insulin a Caregiver dripped the insulin on the floor and a staff member who had dealt with [Mrs A] inappropriately was not disciplined as [Ms B] had expected

   a. The management of facility staff and the appropriate management of discipline is that the staff member gets to explain their behaviour which in this instance was found to be acceptable to [the rest home] management. It was not acceptable to [Ms B] when she learned of it afterwards. Perhaps communicating with her would have meant that she accepted the decision that [the rest home] management had taken. If she didn't accept the results of the decision she could have chosen to have this carer excluded from her mother's care.

This is a mild departure from the standards as it is seen as a communication issue, not about the actions of the staff member.

3. The monitoring of the correction dose of insulin blood sugars did not occur

   a. If correction doses were charted to be given in response to a blood sugar level after insulin had already been given then at least two hourly blood sugars would be an expectation. This was not done but continued to be recorded as part of the action plan.

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This is a serious departure from the standards.

4. Podiatrist management for the heel wound was not followed — a herbal poultice was used

    a. It appears that this was the case and the Podiatrist's letter of 2/5/11 clearly states the deterioration in the wound over the previous month. The Podiatrist's 11/1/11 letter indicates the wound's improvement since [Mrs A] was in hospital and in reviewing her letters of 7/2/11, 7/3/11 and 4/4/11 she indicates a deterioration of the wound which if matched with [the rest home] wound charts is the time that honey and dock poultice were used.

    A fundamental wound management practice is to ensure consistency in the dressing and whilst manuka honey is used in wound management I could find little on dock poultice and there was nothing apart from some anecdotal comment provided in the [the rest home] material regarding their possible benefit.

    These alternative therapies being discussed with the family/[Ms B] and [Mrs A].

    The only information included here is [Ms B] not wanting these products to be used and no evidence of them improving the wound. In fact, the wound heals following the consistent dressing applied. The documentation improves after the May visit with the use of a new wound monitoring chart, this perhaps indicates input from the wound specialist as noted in the notes by [RN J].

This is a serious departure from the standard of care that is expected to be provided. This would be an opportunity to use the Family Contact form to record the discussion regarding this.

5. A diabetic menu wasn't followed

    a. This is a difficulty in all resthome and hospital care as the staff strive to have a home like environment and of course one of the things about home is having the things you enjoy. There are a number of points here — the lack of variation in the morning and afternoon teas provided to Residents. This was obviously addressed.

    The belief that not following an appropriate diabetic diet was contributing to the variation in [Mrs A's] blood sugar levels.

    In order to assist in determining this there was a decision to monitor [Mrs A's] intake by using a food diary. The food diary was not completed correctly as evidenced by the omission of the ice cream and jelly that [Ms B] was present to see her mother eat. The completion of charts such as this is dependent on commitment and understanding of all staff to write down all types of food including those that would be on the menu for the day. There is nothing in the notes to indicate that [Mrs A] didn't eat the meal she was presented with — there are comments regarding her helping herself to others' food at meal times.

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Given the need for this information to contribute to [Mrs A's] better health and its inception was the result of a complaint, it would be reasonable for the Manager and the RNs to have been involved in monitoring the completion of the food diary, to ensure it was completed correctly. It does not appear that this happened as there is lack of reporting noted in the food diary. No doubt, this contributed to the lack of trust that [Ms B] was already experiencing.

Given that there were a number of other diabetics (as identified by [the rest home] management) and this occurred over a prolonged period of time this is considered a moderate departure.

6. Physiotherapy plan for post surgical removal of the rod in [Mrs A's] leg was not followed

    a. When I checked the Eldernet site regarding [the rest home] there is no mention of a physiotherapist being available in the Resthome area and there is a comment upon [Mrs A's] return from hospital that [Ms B] was unsure of what the requirements for physiotherapist referral is. [The rest home] acknowledged this did not occur as instructed with the onus put on the care staff for not completing the regime. The responsibility for monitoring this programme was with the Registered Nurse and that it was not being done for two weeks goes beyond the few days that might [be] expected to escape Registered Nurse monitoring especially as the discharge letter from the hospital noted she was not compliant.

This is considered a serious departure from the standards.

7. Following a diabetic incident [Mrs A] was not transferred to hospital

    a. Such situations are difficult to manage however, the GP indicated that if the family wanted [Mrs A] to go to hospital he was happy with that. Given this, [Mrs A] should have been transferred to hospital with the information about the situation provided to the hospital. This would have meant that the hospital staff could speak to [Ms B] as the family member. This transfer may or may not have resulted in admission but it would have given [Ms B] a sense of being heard and if the transfer was needless this would have re enforced the correct actions proposed by the [the rest home] staff.

This is a severe departure from the standards that a Resident and their family should be able to expect. This comment is made on the basis of the acknowledgment from the Doctor that a transfer was acceptable and what the family requested. It is not based on any clinical comment of the actions taken by the staff which were well documented.

8. [Mrs A] fell 15 times in 15 months

    a. Whilst the number of falls seems significant it is the treatment of them in not advising her daughter of them except on a few occasions and the assessment of her at the time, no assessment regarding blood pressure and blood sugar level. It clearly says in the 2010 careplan that [Ms B] wants to be included. Despite this when adverse events occur [Ms B] is not called.

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There is no recording in the notes that [Mrs A] was asked if they should contact [Ms B] and said ‘no’. This was identified as an issue in the 11/11 audit and is commented [on] in the conclusion of this report.

This is considered a serious departure from the standards expected.

9. The restraint/enabler assessment was not followed.

   a. The restraint form was completed on February 2012 after the second femur was fractured. This followed an 18/11/10 conversation between [RN C] and [Ms B] regarding the use of restraint such as bed rails to limit [Mrs A’s] mobility. The decision, which is a sound one, was not to use restraint at this time — 11/10.

      When the restraint form was completed in 2/12 it advises that the bed rails will be monitored two hourly. There is no monitoring form provided and no evidence in the notes that the rails were put up and down when [Mrs A] was either in or on her bed.

      Documenting in the progress notes that bed rails have been monitored two hourly is a common practice to minimise the need for another monitoring form and would normally be in the care plan (where it is noted) and progress notes — which it is not. There appears to be little evidence of recording that the bed rails were being put up and down and being monitored.

This is considered a serious departure from the expected standards.

10. Of 20 adverse events [Ms B] was advised of five.

    a. This is a requirement of all facilities and the need for this increases as Residents are less able to be involved in their decision making and care. It is in [Mrs A’s] careplan that [Ms B] wishes to be involved in all decisions. It is evident that [the rest home] had all the correct processes in place for this to occur such as a form for documenting contact with the next of kin and an adverse event form which has a place and time for family contact. It was a finding in [the rest home’s] November 2011 audit that this was not being done adequately — there is no information provided about how [the rest home] have addressed this finding. There are incident forms after the 11/11 date that family have been advised of as there were prior to that time so whether the audit results made any difference to [the rest home’s] practice in this area can not be determined in this review.

This is a serious departure from the expected standards and was addressed at the 11/11 audit.

11. Inadequate handwashing techniques as [Mrs A] had been ESBL positive and had been MRSA positive. Not using gloves to undertake a blood sugar level recording.

    a. As noted by [the District Health Board Charge Nurse Manager] in the email of 23/3/12 management of ESBL and MRSA in a long term care facility is different to that in a public hospital. [The District Health Board

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Charge Nurse Manager]advises that [Mrs A] should be treated as all Residents are treated by using standard precautions. In February and March 2012 there were additional instructions provided to the care staff regarding infection control precautions. It appeared from [Ms B's] complaint that despite the instructions given in a variety of means; memos, with staff pay slips — this did not occur.

Infection control procedures and training were well described by [the rest home] but there is no actual information about who was trained, when and about what. This particular complaint provides many opportunities to work with Residents and families as well as staff regarding improving this aspect of care and service.

Given that there were no specific issues arising from this it is a demonstration of a missed opportunity to educate family and Residents. It is included as a mild departure from the standards expected.

12. No accessible bell resulting in a fall which resulted in a right fracture [of the] neck of femur

    a. This was explained as a serious error following [Mrs A's] room change. Given that it is known she is confused, a high falls risk and that she would be new to the staff in the area this is a serious failure in the care provided.

       Whilst this is an understandable error that makes it no less significant as it resulted in the second fracture and as the national falls prevention information identified environment is a key issue and the [the rest home] staff had the opportunity to control this. As they failed to do this the result was a fall which could have had fatal consequences on a woman of [Mrs A's] health issues — fortunately it was not.

This is a serious departure from the standards.

13. A urine sample should have been taken in March post catheter removal was not taken until [16]/3.

    a. [Mrs A's] 2010 care plan indicates that she is not continent and this complicates the ease of obtaining urine samples. Whilst this may be complicated it is not impossible as most people will urinate after given fluid so if this urine sample was seen as a serious and necessary requirement it could have been obtained — it may have been late.

       However, if the lateness was explained to [Ms B] then it could be anticipated that this would have been acceptable. It appears that it was either not seen as essential (in the light of the complaints [Ms B] was making this would be unlikely) or was overlooked and then the communication about this was not conveyed to [Ms B] and when it was it was incorrect. Given the nature of weekly meetings happening at this time this seems to be a serious omission of information and was a finding in the November 2011 audit.

This has been identified as a mild departure from the standards, again more about inadequate communication.

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14. [Mrs A's] foam boots were not always put on and a pillow was put under her legs.

    a. Having read the notes there are a few times staff record that [Mrs A] did not want them on. Compliance seems to have been an issue for [Mrs A] and perhaps as a result of this care staff neglected to take this as a serious instruction particularly if they omitted to do this in front of [Ms B]. There were notices in care staff areas and there are a few times that the care staff record that she did not wish her boots on. Not following instructions or new instructions must be recorded in the progress notes with what was done recorded.

This is considered a serious departure from the standards expected.

15. A transfer belt was a requirement for [Mrs A's] care but was not always used.

    a. In doing this review it was difficult to determine [Mrs A's] mobility needs as they changed with injuries and following the surgery to remove her metal work. Reviewing the incident forms it is evident that most incidents are recorded as occurring between 2 and 7:30pm, times when staff numbers are minimal. This variability in her mobility is identified by the RN who emphasises the staff are aware of this and can make decisions regarding this. Notably there are more comments regarding her mobility in 2–3/12. This may be the result of the new fractured femur or as a result of direction by the RNs.

       However, the assessment was for the use of a transfer belt/a two person transfer. This is recorded in her care plan, in the Doctor's notes and the Physiotherapist plan — despite this [Mrs A] mobilised on her own, with only one care worker or without the transfer belt. As in point 14 if instructions are not followed then this must be recorded in the progress notes with what was done recorded.

       Access to a Physiotherapist at [the rest home] is unclear and when looking on the current Eldernet site it appears that there is not a regular Physiotherapist at [the rest home]. This is a definite area that requires attention as it is often mobility issues that are the centre of such concerns and it is essential that Registered nurses have this level of expertise available when planning care and support of Residents.

       Notably [Ms B] notes that [Mrs A] remains a two person transfer in her new home; this may be indicative of the new home following instructions but it also may be indicative of [Mrs A's] deteriorating condition or lack of having her mobility encouraged.

This is a serious departure from the expected standards and the management of mobility issues is critical to the care and support of older people.

16. Resthome audits did not deal with the issues [Ms B] identified

    a. [Ms B] refers to the [the rest home] audit undertaken in November 2011. The service at that time was noted that it needed to improve family/whanau notification — how this was done is not identified in the

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information [the rest home] provided. This audit found no areas of concern regarding skill mix and safe staffing, the diversional therapy programme and the menu that is used.

This article was written in June 2011, just prior to some major changes undertaken by the Ministry of Health to address deficits observed in audit practices and the information that they provide. The November 2011 audit was undertaken with a different focus from earlier audits with a greater focus on tracer methodology. This said these audits are still dependent on the files that are available to the auditor. This means that the specific issues that [Ms B] wishes to have addressed could have been missed just by the files chosen. Auditors would have looked for files with a chronic wound — [Mrs A's] wound was healed, she was not on restraint which would have been another reason to look at the file.

What would be of interest would be to know how families are advised of impending audits and the results of audits. Do the families of [the rest home] residents have an opportunity to meet with the auditors as this contributes to the concept of open disclosure?

It is impossible to determine as well as being beyond the scope of this whether the matters that arose at audit have been addressed by [the rest home]. There is an assumption that [the rest home has] had the opportunity to respond to the concerns including this one and there is no information about what corrective actions they took to the findings that were found.

17. [The rest home] did not provide [Rest Home 2] the diabetic protocol for [Mrs A] upon her transfer to the new facility, [Rest Home 2]

    a. The material that was included here as the transfer information included the diabetic protocol and the medication chart. Given the complexity of [Mrs A's] care issues it would be expected that a transfer letter would be provided and possibly some sort of verbal handover, none is recorded in the [rest home's] notes. If this had been given some time later it would be acceptable to see it added into the progress notes retrospectively as some other documentation in these notes are.

       On the 29/3/11 it is recorded by a member of the care staff that [Mrs A's] daughter, [Ms B] was given her blister packets and a copy of all documents. What all the documents are is not specified and this staff member's signature is not legible.

       In the absence of a specific form for this type of transfer perhaps the same form that is used to transfer a Resident to hospital could have been used as well as providing the current support plan and the short term care plan. The purpose of this would be to ensure that the care for [Mrs A] was as seamless as possible so that the new facility was aware of what her needs were.

       In [Ms B's] material regarding the discharge notes from the [the rest home] she adds that [Mrs A's] 29/6/12 admission to hospital was as a

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result of the inadequate information provided to the new facility. However, given that this was a new admission to a new facility there should have been a new care plan that was gone over with the family/[Ms B] which would have provided the opportunity to discuss her diabetic condition which would have included the ketone monitoring which [Ms B] knew all about. Therefore, this element of the complaint is not included for consideration here.

In conclusion:

It is important to understand in the identification of whether these complaints are mild, moderate or severe includes an assessment of not only about what did occur it includes considering the potential of what may have occurred. In a number of these complaints no physical harm has occurred however there could have been and as such it is reasonable to consider the potential and the need to manage these risks.

It is necessary to remember that [Mrs A] apart from after her return in late February, was in a residential facility and the standard of documentation whilst it is acceptable and covers areas of hygiene, continence, [Ms B] and some other family visiting, blood sugar monitoring, food intake on occasions, mobility it is lacking in the other aspects of [Mrs A's] life such as activities, things she enjoyed. [Mrs A] is described as being part of [rest home] life; however, [Ms B] notes she is in her own room every afternoon. There was no activity plan provided and few notations made about activities by the care staff or the Diversional Therapist in the progress notes. Comments regarding her ability are infrequent and it would be helpful to remember this level of documentation for the future. [The rest home] had good systems in place with respect of documentation such as the RN stamp and family contact forms. However, Nurses often didn't use the RN stamp and it is not easy to identify information recorded by specialist nurses, physiotherapist and the Diversional Therapist.

I wish to reiterate my earlier commendations to [rest home] staff and [Ms B] regarding the commitment to attend weekly family meetings to discuss complaints. I believe that this demonstrates that [Ms B] was committed to [the rest home] and did appreciate and value most of what was happening for [Mrs A]. The responses by [rest home] staff to [Ms B's] concerns are well documented and demonstrate a clear intention of [the rest home] to address the complaints.

Dealing with complaints and working with staff at all levels to ensure they are addressed is difficult, particularly when staff believe they are doing the right thing. This is an area where there is little training and development offered to our industry. In my experience once trust and confidence has been lost no matter how hard both parties try it is virtually impossible to fully resolve the situation and whilst it is regretful that [Mrs A] left [the rest home] I do think [Ms B] made the best decision she could.

Whilst out of the [17] complaints there were [11] noted as serious departures from the standards many of these are historical and were being addressed prior to [Ms B] moving [Mrs A]. As well as this an audit occurred in 11/11 for which there would be corrective actions required to be taken and the review of these and

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possible improvement is beyond the scope of this report. Part of the current audit process includes spot audit where no notice of the actual day of audit is given. In doing this the District Health Board can also direct the Auditor to look at particular aspects of service provision. I hope this gives [Ms B] confidence that the matters she identified have either been addressed for future Residents or will be addressed.

Julia Russell RN BN, M Phil"

Further advice was obtained from Ms Russell as follows:

"10 March 2014

Report re: [Mrs A], C12HDC00915

Thank you for the opportunity to further review this case. This report has been prepared in response to the formal investigation initiated by the Deputy Commissioner, Complaints Resolution. The purpose is to determine whether the services provided to [Mrs A] by [the rest home] and by Registered Nurse [RN C] were appropriate for the care and support required by [Mrs A]. The advice required is in reference to the sector standards, professional nursing standards as well as:

a) whether the assessment(s) and documentation of [Mrs A's] needs and care upon admission and throughout her residency were appropriate

b) whether the care provided to [Mrs A] from November 2010 was consistent with rest home care. If not please provide examples or specific details

c) whether the care provided to [Mrs A] from 24 February 2012 was consistent with hospital level care. If not please provide examples or specific details

d) whether you consider that [Mrs A's] diabetes, falls risk and wound care were managed appropriately during her residency. If not provide examples or specific details

e) whether [Mrs A] was appropriately monitored between 21 and 23 December 2011 (including whether you think the hospital was clinically indicated as at 23 December 2011

f) whether there was appropriate communication between [the rest home] and external specialists involved in [Mrs A's] care (including Podiatry and Diabetes Clinics); and

g) whether [Mrs A's] competency status causes you to confirm, change, amend, add to, qualify or depart from the preliminary expert advice in any way.

It is also important to note if there is any conflict in the evidence in which case I will provide my advice in the alternative. I will address the six points above and reference the Registered Nurse competencies, the Health and Disability Sector Standards (2008) and the Aged Residential Care Agreement as necessary.

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Professional nursing standards

I have reviewed [RN C's] responses in the context of the requirement for all Registered Nurses to meet the New Zealand Nursing Council 2007 competency requirements (reprinted December 2012). There are a complete set of four domains. In reference to [RN C] I am referring to domain 2 — the management of nursing care (indicator 2.8), domain 3 — interpersonal relationships (indicator 3.1, 3.2) and domain 4 — inter professional healthcare and quality improvement (indicator 4.1, 4.2). These competencies include requirements for Nurses working in management.

Domain 2, indicator 2.8 is particularly about Nurses reflecting upon and evaluating with peers and experienced nurses, the effectiveness of nursing care. This competency expects that the Nurse evaluates their own level of competence and seeks assistance and knowledge as necessary. The competency for nurses involved in management in this competency requires the Nurse to promote an environment that contributes to on going demonstration and evaluation of competencies. The Nurse would promote a:

> Quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.
>
> Practice environment that encourages learning and evidence-based practice and participates in professional development.

Domain 3 refers to interpersonal relationships with competency 3.1 requiring Nurses to establish, maintain and conclude therapeutic interpersonal relationships with health consumers. It focuses on initiating, maintaining and concluding therapeutic interpersonal interactions with health consumers and incorporates therapeutic use of self and psychotherapeutic communication skills as the basis for nursing care for health consumers with mental health needs. As well, it requires the Nurse to demonstrate respect, empathy and interest in health consumers as well as establishing rapport and trust with the health consumers.

Competency 3.2 requires the Nurse to practise nursing in a negotiated partnership with the health consumer where and when possible. This means undertaking nursing care that ensures health consumers receive and understand relevant and current information concerning their health care that contributes to informed choice. This includes implementing nursing care in a manner that facilitates the independence, self-esteem and safety of the health consumer and an understanding of therapeutic and partnership principles. It also recognises and supports the personal resourcefulness of people with mental and/or physical illness. It also acknowledges family/whanau perspectives and supports their participation in services. For nurses involved in management this competency requires establishing and maintaining effective interpersonal relationships with others, including utilising effective interviewing and counselling skills and establishing rapport and trust. Further to this, it requires Nurses to communicate effectively with members of the health care team, including using a variety of effective communication techniques, employing appropriate language to context and providing adequate time for discussion.

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The final competency that relates to this situation is domain 4 — inter professional healthcare and quality improvement. In particular, competency 4 which recognises and values the roles and skills of all members of the health care team in the delivery of care. This is achieved by the Nurse contributing to the co-ordination of care to maximise health outcomes for the health consumer. Competency 4.3 refers to the Nurses participating in quality improvement activities to monitor and improve standards of nursing including reviewing policies, processes, procedures based on relevant research. To demonstrate this, the Nurse recognises and identifies researchable practice issues and refers them to appropriate people and distributes research findings that indicate changes to practice to colleagues.

Utilising the Nursing Council competencies for a RN and reviewing the actions of [RN C] in this situation on most occasions the competencies and associated indicators are met. The times when they are not are with respect of the

i. Diabetic management — the post correction dose follow up
ii. Not meeting the open disclosure requirements regarding the 'events — falls' that [Ms B] was not notified of
iii. The care plan was not written by [RN C] as this was not her role — however, it would be her role to ensure that there was a process in place to ensure it was an accurate reflection of [Mrs A's] requirements, her dressing was being done adequately — have a plan for dressings that don't heal — this might include involvement of the wound specialist
iv. Clarifying the communication channels and what needed to be communicated — this includes the treatment of [Ms B] as the next of kin and/other EPOA

<u>Requirements of the Aged Residential Care Services Agreement and Sector Standards</u>

These complaints occurred in 2010–12 and the current agreement has changed little particularly in reference to what is expected of the care planning process and the associated expectations. I have commented through the rest of the document of where I believe this process did not meet expectations — these include reflecting [Mrs A's] cognitive state and the variability that existed in respect of her complying with care requirements including — mobility, diet, medical support. However, in other areas such as preferred priorities of care, (p.99) preferences which looks to be the beginning of advance care plan, they exceed the expectations of the agreement expectations. The preferred priorities of care documented is also noted in [RN C's] response as an example of innovative practice which she was responsible for implementing and is consistent with the expectations of RN Competency domains 3–3.2 and 4–4.2.

The Health and Disability Sector Standards 8134.4 2008 require providers to provide services to meet a particular set of standards. This includes a practice called open disclosure which is:

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> A timely and transparent approach to communicating with, and supporting consumers when things go wrong. This includes a factual explanation of what happened, an apology, and actions that deal with the actual and potential consequences. An important aspect of disclosure is explaining to consumers how the incident has been reviewed and what systems will be put in place to make sure similar incidents will not happen again. Standard 1.9, Criteria 1.9.1

Open disclosure is where [the rest home] and [RN C] in her role as Care Unit Manager needed to focus their efforts. Given [Mrs A's] physical and mental health irrespective of whether or not there was an EPOA and whether or not it was activated the consumers concerned here were both [Mrs A] and [Ms B]. There are a number of things that were not treated in this manner. [RN C] advises that many things were discussed with [Mrs A] unfortunately these things are not recorded.

The sector standards also determine the standards around risk management, infection control and restraint minimisation. [RN C] in her June 2010 letter to [Dr P] and [the Diabetes SL] regarding [Mrs A] identifies a potential risk which leads to the change in the level of care [Mrs A] receives. I believe [RN C's] management of restraint — not implementing some form of physical restraint is in keeping with the standards. Bedrails were put in place after the February 2012 faIl and return to [the rest home].

[Mrs A] was ESBL+ and the actions taken at a public hospital are different to those at a resthome level. At the 2011 certification audit the infection control practices and knowledge are in keeping with current practices for long stay facilities. With the increasing number of antibiotic resistant infections infection control is of increasing importance to Residents, Staff and Facilities. Unfortunately, despite all Managers' best efforts, there will always be someone who does not wash their hands at the correct time as occurred with [Ms B's] observation of this. [RN C] can only be judged by what she puts in place and how this is monitored and it appears that the appropriate things are in place.

a. *whether the assessment(s) and documentation of [Mrs A's] needs and care upon admission and throughout her residency were appropriate*

The initial assessment undertaken at the time of admission to the [rest home] in 2010 was comprehensive and holistic, the evaluations are done three monthly which exceeds the sector standards requirements for resthome care at the time.

[Mrs A's] initial [rest home] assessment and her Needs Assessment state she is a 'one person assist with a low walking frame'. Note that she is identified as requiring a walker and 1 person to assist in her care (p. 73). In the care plan and summary provided by [the current general manager] (p.2) she is described as requiring two people to assist, this change in care requirements was the result of a fall on 3/11/10. I have commented on this as it is one example that demonstrates the staff being responsive in meeting [Mrs A's] changing needs. [Mrs A's] compliance with aspects of her care was an on going issue throughout her stay at [the rest home].

In reviewing these notes, I was checking for a diagnosis of dementia or impaired cognitive function. This is included in the 2010 assessment by the Needs Assessment Service Co ordination (NASC) Team. [Dr D] refers to [Mrs A's]

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inaccuracies in providing history (p.1) in his 28 October 2013 letter to [HDC's] Legal Advisor. Few of the formal documents identify [Mrs A] as having dementia. The preferred care area (p. 101) seems to be the only part of the [the rest home] care plan that identifies [Mrs A] as being forgetful and slightly confused. Note: carrying of assessment data through to the care plan is one of the audit findings in the May 2013 Certification Audit.

The Falls Risk and Skin Assessment tools are complete. However these particular tools are limited as they do not identify what actions are to be taken for a score of 6 or for someone with pressure areas.

Short term care plans are used with appropriate interventions and evaluations and are not only reactive in the case of the fracture but are also proactive as evidenced by the pressure area management when the L) heel was noted as soft and the possibility of a deep vein thrombosis. There are nutritional profiles used, appropriate monitoring forms for blood sugars, medication administration, wound management. The wound management form that was received in this series of documentation from [the rest home] is only one of a series of forms I received in the last review. I have attached both to this report as the wound management process needed review as there is evidence of multiple forms being used.

There are references by [RN C] in 24 September 2013 regarding a relationship of mistrust between [the rest home] and [Ms B]. It is not clear when or how this has occurred. However, [RN C] records in her interview and statement that she endeavoured to speak with [Ms B] on a daily basis. Unfortunately, this is not recorded in the care plan or evidenced in the concerns raised by [Ms B] that she had that regular contact with [RN C]. I am not saying that this daily contact did not occur but it was perhaps not identified to [Ms B] as a means of raising and resolving concerns. The Family Notification Form appeared to be a new form in the 2013 review and was perhaps developed in recognition they were not responding appropriately to complaints. This form was used occasionally and does not appear to have been regularly used by [RN C] in her conversations with [Ms B]. Included below is a time when the Family Contact stamp was used when Staff are talking to Families.

cont'd No heat, no obvious swelling.
Old bruising above & below knee from
surgery [illegible] is refusing regular
panadol Given paracetamol at 1430hrs
[illegible] reluctant to walk c/o pain.
See Short term C/P for exercises
before getting up in morning &
at bedtime. [illegible] aware
of above actions.

1. *Whether the care provided to [Mrs A] from November 2010 was consistent with rest home care*

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The notes as Appendix A record that the admission information included [Mrs A's] requirements as including poor short term memory. It is documented in the NASC assessment (p. 546) that [Mrs A] experiences mild cognitive loss and this is increasing due to fluctuating memory loss and she also has low motivation — related to health issues and pain. This is not transferred into the care plan or the activity plan which is unfortunate as this may have assisted on going documentation when [Mrs A] was not complying with recommendations such as the foam boots and explain why she continued to mobilise without assistance. There is also a missed opportunity here to explain [Ms B's] role and the contact [RN C] identifies as having daily. This care plan was signed off by [Mrs A] and it is probable that [Ms B] never saw this — this is another missed opportunity as it would have explained the FSBL management. I note that the care plan reviews are noted as requiring improvement in the May 2013 certification audit. Also reviewing the care plan and associated progress notes in a more formal way could have clarified for [Ms B] the actions and care that the staff were providing. This would have been in her role as someone identified in the care plan and in the role of EPOA (even if it was inactive) with the Resthome and [Ms B] as a family member who was very concerned and involved with her Mother.

Wound management — this matter is covered elsewhere however on one occasion there were 6 days between dressings when it was recorded to be done every 3 days (on the wound chart).

In reviewing the care plan the physical needs were well addressed however, the other aspects of [Mrs A's] needs were not. Most of the care provided in a resthome environment is provided by care staff. The monitoring of falls and reporting of same by the Staff is well done and follow ups are as required. The material provided is consistent with Resthome care.

b. Whether the care provided to [Mrs A] from 24 February 2012 was consistent with hospital level care.

[The rest home], as noted by [Dr D's] report, was undergoing significant change at this time with an increase in size and bed numbers. In February 2012 it is apparent at this time that there was a change in the level of staffing with increased Registered Nurse input over the 24 hour period occurring. The management of [Mrs A's] insulin appears to have become a Registered Nurse requirement in February 2012. [Mrs A] had a chronic wound on her L heel — the dressing plan states a dressing to be done every 3 days. This instruction for her L heel [was] not being followed, this dressing was most often being done every 4 days.

[Mrs A] returned to [the rest home] in March after her February 2012 hospitalisation — her level of care and dependency had increased as is evidenced in notes and discharge letter; her ability had decreased, she was not a candidate for active rehabilitation and any improvement would take time. Reflective of her reassessment there is a:

i. new short-term care plan written for the 22/3/12 which included formal recognition of earlier issues — the risk of deep vein thrombosis (DVT) and the potential for further pressure areas. The application of the foam boots is recorded in the notes.

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ii. restraint assessment was put in place (no short term care plan for this) — [Mrs A] continued to want to mobilise and did mobilise on her own therefore the bed rails were put in place and were to be up when in bed. The correct assessment process was in place however there was no evidence of monitoring forms or the process used. The rest home may have recorded their restraint monitoring in their daily notes. If this was the case the bed rails were not up very often, as they are not regularly recorded as being put up.

Note: a complete care plan was not rewritten at the time of [Mrs A's] return to [the rest home], despite her change in level of care. This is not unusual but is a possible contributor to the concerns raised in this report and in the earlier one regarding the missing aspects from [Mrs A's] support plan such as a plan around her memory loss and lack of motivation. There were a number of opportunities to gather and plan for this aspect of [Mrs A's] care however, these opportunities were lost as they were not acted on. A number of areas around care planning were identified in the May 2013 Certification Audit and are noted for action to be taken for improvement.

[Mrs A] was ESBL+ and staff are provided with reminders about this with memos to staff regarding [Mrs A's] management. [Ms B] had complained in February regarding the care and support of [Mrs A]. One of the outcomes of the concerns raised at this time were meetings established with [RN I]. The establishment of these meetings reflects the complaints by [Ms B] and [Mrs A's] complex needs of and the importance [the rest home] placed on resolving these issues.

Whilst there were a number of aspects of [Mrs A's] care that are not well recorded the level of care [Mrs A] required and was provided was consistent with hospital level care.

d. *Whether you consider that [Mrs A's] diabetes, falls risk and wound care were managed appropriately during her residency.*

Diabetic management

This needs to be taken in context with the level of care that [Mrs A] was requiring at the time. [Mrs A's] initial admission was at resthome level in 2010. However after her 2/12 admission and return to [the rest home] in March she had become hospital level. I am aware that there have been concerns raised by aged care providers regarding caring for insulin dependent diabetics in Resthome situations across New Zealand and with the administration of insulin by care staff. However, [the rest home] care staff who were involved with [Mrs A's] diabetic management had been trained and deemed competent by the person doing the assessment. There was poor technique commented on by [Ms B] on one occasion and the Care Unit Manager took the appropriate action which, with the benefit of hindsight, would have benefitted by a discussion with [Ms B]. There is frequent comment from [Ms B] regarding her need to monitor ketones. Instructions for this are not recorded on the sheet of instructions for [Mrs A's] diabetic management or [Mrs A's] personal care plan which was dated 8/10/11.

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In reviewing all the blood sugar readings and care notes there are few occasions that any further blood sugar testing was done following a correction dose recorded on the recording sheet. This is despite it being a requirement for her diabetic management. There are a small number of occasions when further monitoring is done and recorded in the notes but not the recording sheet. This is not helpful when it is the recording sheet that would be used for review by the General Practitioner or Diabetic Nurse Specialist. On one occasion a week's monitoring was sent to the Diabetic Clinic and that week there was at least one recording missing off the sheet. When [Mrs A] experienced a low blood sugar reading there is evidence of follow up actions and readings being taken.

There are typed instructions for the Diabetic Management regime, however when doses are changed they are not always signed for (p. 305). On some of these instructions it is recorded on the document footer where the document has come from but it does not say that on all of them. There are references to the use of ketone monitoring process in a letter sent to [the rest home] on the 15/11/10 by [Ms F], Clinical Nurse Specialist following a visit. In this letter the use of ketone monitoring is referred to but not identified as when — how often. The only reference found to ketone monitoring apart from [Ms B's] concerns that it wasn't done, is recorded in Appendix A (p.7) — that it is to be done after two blood sugars higher than 18. As ketone monitoring is usually done when blood sugars are over 20 it appears that this was not well communicated to the wider team.

[Mrs A] having blood sugars over 18/20 are not a frequent occurrence. On one occasion, it is recorded in the notes that testing did not occur as the equipment was not working and on another occasion it was not done with no recording of why this had not occurred. The requirement to do this is not on the typed instructions for [Mrs A's] diabetic management and it is apparent in reading the associated material that the plan for doing this was unclear. In both the documents responses from [the current general manager] and [RN C] (p3) they have reflected that their actions on this area could have been better and have provided evidence that this improvement has occurred.

<u>Wound management</u>

[Mrs A's] heel was a long-standing problem and was no doubt complicated by her diabetic state. Resthome staff did not attend these clinics and therefore were reliant on the written documentation and feedback from the Clinic from those who attended — [Ms B] as to the actions taken.

There are times when the Diabetic Specialists and Podiatry Clinics contacted [the rest home] staff and this appears to be well documented in the progress notes. A visit to [the rest home] by the Nurse Practitioner (NP) — Wound Specialist on 27/5/11 is recorded in the notes, her advice was to use Aquacell on the L heel and the notes indicate that because of other co morbidities the NP felt it was unlikely to heal. On the 15/6/11 it is recorded that the Podiatrist is happy to continue with the dressing and it appears that the dressing did get to an all but healed stage on the 29.6.11. At this time, the Nurse records to continue with the dressing as the wound had broken down at this stage before. The recording and frequency of dressings from 11/10 until 4/11 was variable and despite saying this dressing was to be done every 3 days it was most often done every 4 days. On one occasion

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there were 6 days between dressings with it done on the 17/11/10 and again on the 4/12/10.

Alternative remedies are used in many areas of practice and [Dr D] reports success with these in the past at [the rest home]. The point here is not that the poultice was an unconventional dressing practice it is that [Ms B] did not wish it to be used on [Mrs A's] dressing. It appears it was not healing on 4/4/11 as stated by the Podiatrist and the actions at this time would have been for [RN C] to clarify the matter as it was a concern for [Ms B]. Clarification could have been achieved by speaking to the Podiatrist or referring to a Wound Specialist (see comments regarding the NP's input). I note in [the current general manager's] response that this is now occurring.

[Ms B] understood that the Podiatrist's recommendation was not being followed and they had told her that at the appointment. After [the rest home] received the 4/4/11 report from the Podiatrist their dressing recommendation was followed.

One of the difficulties is interpreting the various charts used for wound management and the way they are used. I recall when I first reviewed this file that there were more wound charts than provided this time, finish[ing] on 11/4/11. This wound healed briefly at this time but deteriorated further and did not heal again until July 2011.

[RN C's] response (p.3) detailed the use of the honey and dock leaf poultice and states that this was discussed with [Mrs A]. It is unfortunate that these discussions are not substantiated in the notes when the poultice was used — note here that [Mrs A] did sign her care plan on the 18/11/10 however this was never re-signed. It records in [Mrs A's] care plan that [Ms B] is to be part of the care planning process so surely she would have been included in discussions which would/should have been recorded. This is necessary for all Residents but most particularly for a Resident with memory loss and who is variable with a daughter who is committed to her mother receiving services to a high standard.

This document by [RN C] clearly relates her actions and decision to the Code of Rights which includes Right 4 — Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

The use of alternative therapies was not recorded as being discussed with [Ms B] and [Mrs A]. The only information included here is [Ms B] not wanting these products used as the wound was not improving. The wound management documentation improves after the May visit to the Podiatrist with the use of a new

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wound monitoring chart, this perhaps indicates input from the NP Wound Specialist.

Given the difference in the views expressed a personal follow up and recording by [rest home] Staff with a discussion regarding this with [Ms B] would have probably resolved any miscommunication. There is excellent documentation around a number of communications regarding care — restraint, falls management [but] there does not appear to be the same level of information regarding the management of the L heel. This could be that it was done but not recorded, which is, as we know, means for Nurses it was not done.

Falls management

The discussion that [RN C] had with [Ms B] recorded in November 2010 regarding the possible risks for [Mrs A] if some form of restraint was implemented to prevent her from mobilising, (at this time [Mrs A] was a resthome Resident) is grounded in good sense. However, the reasons for [Mrs A] not complying with requests not to mobilise and the potential for her to remove any form of restraint, as she was confused and did not always have good insight into her situation is neither well documented nor included in her personal care plan. I believe this has contributed to the substance of this complaint. This particular event demonstrates [RN C's] ability to record events of significance and to do that to a high standard, this ability is not consistently replicated in other areas of her documentation and would be expected to in her RN competency; 2.8 and 3.2. The actions taken in response to these falls were certainly consistent with good practice with the increase to two people required to mobilise when there were issues — the use of a transfer belt. [RN C] in her interview 15/1/14 (p.7) describes bathing in the spa bath with early mobilising occurring to assist [Mrs A] to get mobile. It is unfortunate that this is not recorded as either a short-term care plan or in the progress notes.

It is recorded that after a hospital appointment [Ms B] wanted to access a Physiotherapist and was unsure how this would occur. However, it did occur in; 9/10, 10/10 and 2/12. The absence of an appropriate and consistent Physiotherapist seems to have been identified as a contributing factor to mobility issues and concerns however, as one RN states, they have sufficient skill and expertise to develop the sort of programme [Mrs A] required and certainly continue the programme that was established in March 2012.

[The rest home] has taken responsibility for improving this area and the use of a regular physiotherapist as described by [RN C] and [the current general manager] will certainly enhance the care they provide for the future.

e. *Whether [Mrs A] was appropriately monitored between 21 and 23 December 2011 — including whether you think the hospital was clinically indicated as at 23 December 2011*

The days between the 21–23 December 2011 [Mrs A] was recorded as being unwell with 'flu like symptoms. [Mrs A's] blood sugars had been rising since the early hours of 20/12/11. On the 21/12/11 RN K records the details of [Mrs A's] blood sugar recording and the associated actions and communications with [Dr D]. It may be worth recalling here that the 23/12/11 was a Friday and from a

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Facility point of view the Registered Staff would want to be assured that any concerns would be resolved before the weekend. The discharge letter from the hospital transfer on the 23/12/11 states [Mrs A] was not admitted, it was a probable urinary tract infection which [Mrs A] was already receiving oral antibiotics for. I have included the insert from [Dr D's] letter regarding his view and comments. Given the benefit of hindsight and the ability to read the notes before and after, this episode appears to have been well and appropriately managed by the [the rest home] Staff with input and support from [Dr D].

> *With regard to her deterioration and admission to the public hospital 23/12/2011. 1 have reviewed the clinical notes rest home record and lab results. She had a proven urinary infection from earlier in December. She had been treated with 7 days of septrin, changed to cector on 22/12/2011 when she was not improving.*
>
> *There was daily discussion or visits from the practice from 21/12/2011 with recommendations about sliding scale insulin doses.*
>
> *By 22/12/2011 (Thursday) she was having 2 hourly blood glucose assessment and her readings were low normal. This would suggest the risk of hyperglycemia and keto acidosis had reduced, presumably the change in antibiotic was more successfully treating the urinary tract infection.*
>
> *Her daughter had phone discussions with practice nurse […] on 22/12/2011 and visited [Mrs A] and assessed her as improving.*
>
> *Reviewing the clinical notes between 15–22/12/2011, there is a record of [Mrs A] being unwell with a urine infection persisting and disturbance of her serum glucose. With contributions from myself, the practice nurses and the [the rest home] registered nurses the urine infection was treated. A first antibiotic proved not 100% effective and a second antibiotic was prescribed. Throughout this week her diabetes was more intensively monitored and her insulin doses fine tuned. This exercise is common in the care of diabetic patients.*
>
> *When I reviewed [Mrs A] 22/12/2011 (time not recorded), I found her to be moderately unwell. She was dry and had not produced urine for some time. She did not have evidence of progressive respiratory or urine infection.*
>
> *Her condition required close monitoring and an increase in her oral fluid intake. Her insulin intake was increased.*
>
> *I am uncertain why she was taken to [the public hospital] on 23/11/2011 (Friday).*
>
> *She was assessed by a [doctor] in emergency not to have an acute problem needing admission and discharged back to [the rest home]. See Appendix 2*

f. Whether there was appropriate communication between [the rest home] and external specialists involved in [Mrs A's] care (including Podiatry and Diabetes Clinics)

There is clear evidence in the notes that [rest home] Staff did not appear to have difficulty seeking advice. This is shown regarding [Mrs A's] return from hospital

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in March 2012; the original plan was to include the use of an air ring and pillows. However, advice was sought and the plan of care was immediately modified as evidenced in the short-term care plan.

Podiatry clinics — this is covered more fully […] under wound management

Resthome staff did not attend these clinics and therefore were reliant on the written documentation and feedback from the Clinic from those who attended — [Ms B] as to the actions taken. There are times when the Diabetic Specialists and Podiatry Clinics contacted [rest home] staff and this appears to be well documented. There was a visit to [the rest home] recorded by the Nurse Practitioner (NP) — Wound Specialist on 27/5/11. The advice from the NP was to use Aquacell on the L heel and the notes indicate that because of other co morbidities the NP felt it was unlikely to heal.

The wound chart records on the 4/4/11 that they were using Aquacel and the notes from that time confirm that.

Diabetic Clinic

Included here is an interaction with the Clinical Nurse Specialist discussion of concerns with [Ms B] on the 22/9/11.

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1500hr	Diabetes Review: — [illegible] to meet with daughter to discuss her concerns re elevated BG's levels.
	> R/V B.G's since insulin increase.
	– Pre-lunch BG's levels consistently high – Range 12.0 — 15.9mmol/L
	R/V Diet – Breakfast – having approx 75grams CHO & 14units Novorapid = noting this limit for each 5grams CHO. Suggest she needs an extra 2units Novorapid with this meal – will get Dr. to sign this off & fax thru order.
	> Daughter concerned that may be having too much marmalade on toast – Discussed & this will be regulated to 1 teaspoon for each slice toast, this will be put on a small side plate.
	B/P checked 120/60
	not unwell, no signs of infection – ? reason for increase in B.G's levels. She has regained some of the weight she lost when unwell this may be cause of insulin resistance.

pm	went to the Diabetes clinic this pm. reported BGL @ Lunchtime was 12.7, & administered Lunchtime Insulin by Daughter reported the Diabetic Podiatry clinic was very happy about wound on her L) heel. – It is healing well & The Diabetic Podiatry clinic will fax the new wound care plan to us. Dressed the wound as per wound care plan. The wound looking good. keep monitoring

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With further recording about interaction with [Ms B] in the following excerpt —

Pm | I came back from Diabetic clinic
at dinner time. Her daughter reported
that got a change in her
RN | Insulin. It's Novorapid 10 units for
breakfast, and 10 units for lunch and
8 units for dinner and 1 unit for
every 2 mmol of blood sugar level.
Also blood pressure were quite
high so she needs to get seen by
the doctor and have to check her
blood for electrolytes, creatinine, urea
and uric acid. please keep monitoring
her blood pressure. The daughter is
very concerned about that

There appears to have been on going confusion regarding when ketone monitoring was to be done. It was not often that [Mrs A's] BGL was greater than 18. There is no recording in the care plan or on the sheets recording diabetic instructions that this was to occur. In [RN C's] 15/1 interview she reflects on the confusion around the ketone management. The question that requires answering is whose responsibility was it to manage this and ensure clarity regarding management. Ultimately it is [RN C's] role and responsibility as defined in her position description to ensure these things are done. However it is in the RN competencies that all Nurses are responsible for ensuring adequate care and attention is paid to this.

Dietician input

This is recorded as having been sought. However, this was not recorded as being communicated to [Ms B].

Contact with the General Practitioner

[Dr D] records his contact as being positive with [the rest home] and that he holds [RN C] in high regard as an expert Nurse.

g. *Whether [Mrs A's] competency status causes you to confirm, change, amend, add to, qualify or depart from the preliminary expert advice in any way.*

[Mrs A] had an enduring power of attorney (EPOA) in place that was not activated. Appendix B refers to my earlier report as referring to [Ms B] as EPOA. I acknowledge that that was how I considered the situation, would direct your attention to my comment that there was little evidence of [Mrs A's] view being sought or that view when sought was recorded. Notable exceptions to this would be the feedback that was sought from the Cook about the diet and [Mrs A] signing

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her own care plan review. Even if the EPOA had been activated I would still have expected [Mrs A's] views to be sought about things she could continue to have been part of. It states in various places throughout her documentation that [Ms B] is to be included in care decisions. In reviewing this situation it is apparent that [Ms B] was seen as her mother's advocate. [RN C] herself records that she spoke to [Ms B] daily regarding [Mrs A's] care so was indeed treating her in the EPOA role.

As indicated in point 2 the inclusion of planning around her memory loss/non compliance may have assisted Staff in recording why this was and seen it as a priority in describing the care provided to her. In the initial assessment and the Resident Registration (p.68) [Ms B] is not identified as the EPOA but is identified as the person to discuss financial, health and welfare with. In the area of the care plan which looks at preferred care — [Ms B] is identified as the EPOA for health and welfare only.

[RN C] in her 15/1/14 interview with [HDC's] Legal Advisor indicates, she considers [Mrs A] as still making her own decisions and she felt restraint would have been 'horrific' for her. The actions she takes are on at least one occasion inconsistent with this. On the 29/3/11 [RN C] signs the release information for [Mrs A's] health information with [Ms B] as EPOA. Whilst [RN C's] interview notes 15.1.14 and [rest home] documentation including care notes suggest that [Mrs A] was still making her own decisions some of which — mobilising independently, the foam boots were neither congruent with [Ms B's] wishes as EPOA nor best practice for a woman of [Mrs A's] complexity. As confirmed by [the current general manager] on p.1 of the [rest home's] response — the EPOA status was never clarified. It appears they were treating [Ms B] as the EPOA, such as requesting [Mrs A's] medical notes, this signature could have been easily elicited from [Mrs A]. This lack of understanding of this point appears to have substantially contributed to the on going concerns and the lack of resolution of them.

In the notes from [Ms B's] interview it is evident that she understands the EPOA process and that her mother was less able to make appropriate decisions for herself when she was unwell and advocated for her strongly at these times. The presence and use of EPOAs would have been a relatively new matter in 2010 and in particular in a Resthome environment where the care would have been traditionally provided to people who were making their own decisions. There is a tenuous area of care and support for health professionals between the wishes of a cognitively impaired Resident and a Family member and often a Facility who wants to be providing care at a higher level than the Resident wants, such as wearing foam boots. This situation demonstrates that difficulty in understanding and for Staff to ensure this and the importance of involving Family at every step of the care planning and process. The question is if this had been activated would the findings previously found be considered differently. No, I would uphold what was found as I believe that the question of activation was not considered by [the rest home] and as noted below is only now coming as a consideration for the Aged Care industry as a whole as we experience these things more frequently.

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21/10/11	0250	Found did not have Pressure boots on at night, encouraged her to have the boots on, but she refused it. BGL=16.0 at 0200. Took one of her two blankets off, encouraged her to drink some water. Also opened the bathroom window a bit to cool down the room a bit. keep monitoring —	

checking machine was not of order. Took her top sheet off & encouraged her to drink H_2O. put boots with the encouragement. reported she was fine, no nausea, headache, etc. BGL = 18.8 at 0640. Encouraged her to drink more H_2O. keep monitoring —

That the EPOAs require activation has been the recent subject of a discussion in the New Zealand Aged Care Association In Touch magazine with the article confirming a letter of activation is required. I would however believe that it is common practice in the Aged Care Industry not to consider the need for activation to have occurred before talking to Families in the event of illness, injury or a requirement of the Resident and certainly to consider the EPOA's wishes in the event of the Resident being unwell or [having] an illness. As we are aware the existence of an EPOA whether activated or otherwise would see the EPOA providing support to the Resident and certainly advocating for the best care and support for them.

It may be that [the rest home is] taking the view that as the EPOA was not activated they were not required to ensure [Ms B] was advised of the care requirements. In [RN C's] response point 9, p.4 it is recorded that [Ms B] completed the restraint documentation as the EPOA in 2012. This further information regarding [Mrs A's] competency status has not caused any departure from the preliminary expert advice I provided in any way.

<u>Conclusion</u>

In my initial report I believe I indicated the difficulty when Residents such as [Mrs A] are going against what would be best practice and the importance of documenting this and talking to Families in order to seek the best outcomes for noncompliant Residents. Given the large amount of extra information provided I continue to see that this is one of the key factors that led to this complaint.

This report requires comment from me on external communication however, at the time of this complaint I wonder about internal communication between [RN C] and then General Manager. The rest home as noted by [Dr D's] report was undergoing significant change at the time with an increase in size and staff

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numbers. This has not been proposed as an excuse by anyone however, it would have influenced communication about the Facility. Also noted is a request by [Ms B] for all of [Mrs A's] care notes in May 2012, stating that this request was outstanding from February 2012. In reviewing these notes I am not clear as to whether [RN C] was aware of whether the initial request was ever responded to or the further request in May. Certainly the lack of action and attention to this request would have been frustrating for [Ms B] and contribute to a lack of confidence and perceived interest in [Mrs A] at a senior level at [the rest home].

I remain clear in my view that there are serious departures from the standard of care that [Mrs A] could have expected. It is clear that [the rest home is] working to address issues at all levels. This is evident by the new General Manager having a clinical background and therefore in a better position to support [RN C] and the entire staff, the new activities around education, planning and support with the new clinical role which will support [RN C] in being assured that the RNs and caregivers are meeting the standards. [RN C] describes this complaint as significant within her professional life and having had significant impact on her thinking about how she practises as a Nurse. This is a positive reflection both on her as an experienced Nurse as well as the [rest home] providing her the support required when faced with this situation.

There are three key issues that are apparent in reviewing this case

- Care planning — lack of consideration for the non-medical aspects of the care and support [Mrs A] required due to her memory loss and non-compliance (note this is noted in the 2013 Certification audit report, standard 1.3.6.1 and 1.3.8.3). Notably this report also comments regarding the management of care plans and short-term care plans. Therefore there will have been significant improvements on this area. These are serious matters as the audit requires that the improvements are actioned within one month. In the response to the report this corrective action for these was completed by May 2013.
- Lack of formal communication, including open disclosure by [RN C] and the wider staff group with [Ms B]. Although as you see in the body of this report Staff did contact her on occasions. This appeared to improve with the increased number of RNs on staff as a result of the February 2012 move to more hospital beds. Nurses know that if it is not recorded then it did not happen. Therefore, much of what is recalled by [RN C] here is not able to be substantiated in the notes.
- Lack of understanding by [the rest home] Staff, in particular [RN C] as the Care Manager regarding the concerns that [Ms B] was experiencing. The prime concern here is the lack of notification of the numerous issues to [Ms B] and the responses to her questions.

The outcome that [Ms B] requests is a follow up meeting with [the rest home] which given the openness in which this complaint has been dealt I am confident will take place meeting the expectations of open disclosure.

Julia Russell, RN, BN, M Phil (Nursing)

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I have attached these two forms as I was not provided the second one in this series of documents and I wanted to ensure this area of wound management documentation is reviewed.

Wound Care Management

Name:

Description of Wound & Assessment: (L) Pressure sore (L) heel.

Dressing – Treatment: ~~(1) every 3rd day cleanse c saline, apply honey, paraffin, gauze + bandage~~
4/4/2011 cleanse c saline apply aquacel cell ~~to the site~~ & a 5 mm field u'd pad (no bandage, please)

Frequency: every 3 days → aqueous cell gel change every 2 days u'd pad get change every 4–6 days.

Date	Time	Evaluation	Signature
23.2.11	1600	Honey, tulle, gauze, bandage. Slow healing	
26.2.11	1340hrs	Dressed as above, reports nil discomfort. Continues to heal slowly	
2.3.11	PM.	Slow healing no inflammation no pain honey tulle bandag	
5.3.11	1115hrs	Continues to heal slowly. expressed some discomf at dressing change. Nil signs of infection.	
9.3.11	1400	Honey, tulle, gauze, bandage. Still some discomfo. No signs of infection	
16 03 11	1645	Dressed as above. Area dry scab. Only a small abscess but quite deep. Nil signs of infection. reports some discomfort.	

HDC

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Wound Monitoring Form

Name:					Dressing Frequency (circle) Daily / (Alternate Days) / Shower days
Date	**Wound Dimension**	**Exudate**	**Odour**	**Pain Assessment 1 - 5**	**Comments Healing, Infection etc**
7.5.11	½ x ½ cm	nil.	Yes.	nil.	aquacel applied.
29.05.11	½ x ½ cm	Nil	Nil	score: 1 when changing the dressing	Applied aquacel as 27.05.11 Dressing Description
31.5.11	½ x ½ cm	NIL	NIL	1	Aquacel,
02/06/11	½ x ½ cm	Nil	Nil	score 1 when changing the dressing	Applied aquacel + cutiplast. area Dry
4/6/11	½ x ½	Nil	Nil	0	Aquacel, gauze, fixomull
6/6/11	½ x ½	NIL	NIL	0	Aquacel applied covered with cutiplast [illegible]
8.6.11	½ x ½	Nil	Nil	Nil	Aquacel, gauze, cutiplast.
11-6-11	½ x ½	Nil	Nil	when changing the dressing	Aquacel, gauze, tap
13.06.11	½ x ½	small	Nil	when changing the dressing	Aquacel. gauze + tape. –small exudate Wound not da
14.6.11	½ x ½	Nil	Nil	Nil	Aquacel/gauze Good improvement.
16.6.11	½ x ½	Nil	Nil	Nil	Aquacel/gauze, tap. wound is looking good.
16.6.11	½ x ½	Nil	Nil	Nil	Aquacel/gauze Tap. Improved. much more shallow now.
18.6.11	as above.	–	–	–	Healing well
23.06.11	As above	–	–	when changing the dressing	came back from Hospital. Aquacel, gauze + tape area dry.
25.6.11	as above	–	–	–	clean + dry. Healing.
25-6-11	as above.	–	–	–	healing, aquacel, gauze & fixomull;
29.6.11	–	Nil	Nil	–	Area appears to be healed but slight [illegible] in heel. D/W Continue c paranet ga
30-6-11	–	–	–	–	Area appears to be healed. continue the same dressing c paranet & gauze
2.7.11		Nil	Nil.	0	tiny area on heal- continued dressing as plan. no pain
04/07/11	–	Nil	Nil	0	tiny area on heal, area dry. Continued dressing on plan. no pain
08/07/11	–	Nil	nil	0	Area appears to be healed. continue as [illegible]
9.7.11	.	–	–	–	Area is dry. Paranet gauze + fixomull applied
12-7-11	sml.	–	–	–	Paranet, Gauze, Fixomull applied.

I have attached this form as I have not seen it used as a monitoring form from March 2013 for [Mrs A's] restraint."

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Appendix B — Wound care records

Recorded wound evaluations over three days apart

2 November 2010 to 2 May 2011

Date	Next date	Number of Days
4 November 2010	10 November 2010	6
14 November 2010	18 November 2010	4
27 November 2010	4 December 2010	7
7 December 2010	11 December 2010	4
11 December 2010	15 December 2010	4
18 December 2010	25 December 2010	7
3 January 2011	7 January 2011	4
21 January 2011	26 January 2011	5
9 February 2011	14 February 2011	5
19 February 2011	23 February 2011	4
26 February 2011	2 March 2011	4
5 March 2011	9 March 2011	4
9 March 2011	16 March 2011	7
17 April 2011	21 April 2011	4
25 June 2011	29 June 2011	4

Recorded wound evaluations over one day apart

27 May to 17 August 2011

Date	Next date	Number of Days
8 June 2011	11 June 2011	3
4 July 2011	8 July 2011	4
9 July 2011	12 July 2011	3
16 July 2011	19 July 2011	3
30 July 2011	4 August 2011	4
8 August 2011	11 August 2011	3

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