Evelyn Page Retirement Village Limited

Registered Nurse, RN E

Registered Nurse, RN F

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01074)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2016, Mr A (84 years old at the time of events) was admitted to a public hospital with a pathological fracture of the right neck of femur. He was discharged from hospital to his home at an independent town house at Evelyn Page Retirement Village Limited (EPRV).[1] At the time of discharge, Mr A was touch weight-bearing only, and had an indwelling catheter (IDC). He had a number of medical problems and was on numerous medications. A referral to the DHB district nursing service was made for the management of Mr A's catheter.[2] A referral was also made to an organisation providing home help. Their responsibility was limited to personal care and home help only.

2. During the week that followed the hospital discharge, Mr A and his wife struggled to cope at home. On Day 1, the Clinical Manager of EPRV, RN E,[3] met with Mr A and his son, Mr B to discuss their concerns. RN E said that she reviewed Mr A's needs and offered him "two days [of] complimentary care", which was accepted.

3. EPRV told HDC that the level of care intended for this service is "minimal" and involves "access to care staff, and oversight from an RN during the day". It added that internal company protocols applied to this service, and therefore:

> "There is no regulatory requirement to undertake any paperwork or observations of these residents as the service is totally private and has no alignment with the DHB. No written consent is required."

4. EPRV explained that generally the service is provided in the rest home unit but, at the time of Mr A's admission, the rest home was full and therefore he was placed in the serviced apartment building connected to the rest home. As such, Mr A's care fell under the responsibility of the senior caregiving staff rather than a registered nurse.

5. Mr A was transferred from his town house to the serviced apartment. RN E explained that she "incorrectly assumed" that no formal admission documentation was required for Mr A because he was an independent resident. Therefore, the only documentation she completed for Mr A was progress notes.

6. RN E stated that she discussed Mr A's needs with the senior caregiver in charge. On a handover sheet, the senior caregiver documented: "Mr A — respite [until] Sunday?" RN E said that she also spoke to a hospital nurse,[4] RN G, about Mr A's care, and had expected RN G to visit him and provide additional oversight. RN E acknowledged that she did not communicate these intentions to RN G clearly and, as a result, RN G did not attend to Mr A on the evening of Day 1.

7. On the morning of Day 2, Mr A's progress notes document that a serviced apartment caregiver informed the Hospital Coordinator, RN F[5], that Mr A's catheter was leaking. RN

[1] EPRV is 100% owned by a company.
[2] Not yet actioned as at Day 1.
[3] RN E is no longer the Clinical Manager at EPRV.
[4] Hospital registered nurses are located at EPRV's care centre, and can be contacted to provide assistance to serviced apartment residents.
[5] RN F is no longer the Hospital Coordinator at EPRV.

F visited Mr A and documented that his "catheter was leaking at penis [and] insertion site". She then advised Mr A that "he would have to go to [the public hospital] to have a new catheter inserted as [EPRV] were unable to do it for him".

8. RN F said that it was her understanding that, as an independent resident, Mr A did not require any documentation, and she was unaware of any policy relating to complimentary short-term care. She stated: "As [Mr A] was admitted to a serviced apartment his care fell under the responsibility of the serviced apartment area …"

9. RN F recalled that Mr A said that he would telephone his son and ask him to take him to hospital. She then left Mr A with the caregiver. EPRV told HDC that the caregiver heard Mr A leave a voicemail message indicating that he needed to be taken to hospital. EPRV stated that the caregiver assumed that the voice message would be received, and therefore informed the serviced apartment senior caregiver that Mr A would be going to hospital with his son. On the handover sheet, the senior caregiver noted that Mr A had "gone with son to hospital re catheter". However, this did not occur and Mr A remained in the serviced apartment.

10. EPRV stated that at 10.30pm the serviced apartment senior caregiver went off duty without updating the handover sheet and alerting the team that Mr A was in the serviced apartment.

11. At 11am on Day 3, Mr B arrived at EPRV to visit his father. An exchange occurred between Mr B and the senior caregiver in charge where it became clear that the caregiver was unaware that Mr A was still present in the serviced apartment. The caregiver and Mr B went to the serviced apartment, where they found Mr A in a distressed state.

12. EPRV told HDC that Mr A's bed was wet and he had removed his catheter bag. Mr B told HDC that he found his father "in a state of shock; cold confused, dehydrated and in pain". Mr B added that his father was "sitting in shorts only on a urine-stained bed" and "his catheter had leaked all the way through his bed … and had dried from the night before". Mr A had not had any breakfast or cares since the previous night. At Mr B's request, an ambulance was called for Mr A and he was admitted to the public hospital.

Findings

13. EPRV did not have adequate policies and procedures in place for the delivery of complimentary short-term care to independent residents. It therefore failed to guide its staff to deliver the service in an appropriate and safe way. In addition, EPRV failed to communicate adequately regarding the service that was being offered to Mr A. It was found that, overall, EPRV did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[6]

14. RN E failed to assess Mr A adequately and to document his needs at admission adequately. She also did not have the requisite knowledge of EPRV policies and procedures around complimentary short-term care, yet was responsible for offering the service to residents. It was found that RN E did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

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

15. The clinical picture that Mr A presented to RN F (a leaking catheter) was clear, and should have triggered an adequate assessment of Mr A with the requisite examinations as outlined by expert advisor, RN Jan Grant. RN F's advice to Mr A to arrange his own admission to the public hospital demonstrated a lack of care, and was inappropriate. Accordingly, it was found that RN F did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Recommendations

16. It was recommended that EPRV:

a) Provide HDC with evidence that RN E and RN F have received the relevant training on EPRV's policies and procedures for 48-hour complimentary care.

b) Provide HDC with evidence that the changes already made to the 48-hour complimentary care have been reflected in current policies and procedures.

c) Provide HDC with evidence that it has reviewed its "48 hour complimentary short term care for retirement village residents" brochure and provide HDC with the outcome of this review.

d) Provide HDC with evidence that it has developed a specific policy for its 48-hour complimentary care service.

e) Provide HDC with evidence that it has audited, over a period of six months, the standard of staff documentation for residents admitted to 48-hour complimentary care.

17. It was recommended that RN E:

a) Provide HDC with evidence that she has undertaken further education on the principles and requirements of admission and care planning in aged care.

b) Provide HDC with evidence that she has undertaken training on effective communication.

c) Provide a written letter of apology to Mr A's family for her breach of the Code.

18. It was recommended that RN F:

a) Carry out a reflective practice case study on the care she provided to Mr A.

b) Undertake further education and/or training on indwelling catheter management.

c) Provide a written letter of apology to Mr A's family for her breach of the Code.

Complaint and investigation

19. The Commissioner received a complaint from Mr A's family about the services provided to him by Evelyn Page Retirement Village (EPRV). The following issue was identified for investigation:

- *Whether Evelyn Page Retirement Village Limited provided Mr A with an appropriate standard of care in 2016.*

20. The investigation was extended, and the following additional issues were identified for investigation:

- *Whether RN E provided Mr A with an appropriate standard of care in 2016.*
- *Whether RN F provided Mr A with an appropriate standard of care in 2016.*

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

22. The parties directly involved in the investigation were:

Mr B	Complainant/son
Ms C	Complainant/daughter
Ms D	Complainant/daughter
Evelyn Page Retirement Village Limited	Provider
RN E	Provider/registered nurse (RN)
RN F	Provider/registered nurse
Also mentioned in this report	
RN G	Registered nurse

23. Information was reviewed from:

District Health Board (DHB)
Organisation providing home help

24. Independent expert advice was obtained from a registered nurse, Jan Grant (**Appendix 1**).

Information gathered during investigation

25. In 2016, Mr A (84 years old at the time of events) was admitted to the public hospital with a pathological fracture of the right neck of femur. He was discharged from hospital to his home at an independent town house at EPRV. EPRV told HDC that its responsibility in relation to Mr A's health care did not change throughout this time and there was no agreement in place relating to the provision of health care between EPRV and Mr A when he was discharged from hospital. At the time of discharge, Mr A was touch weight-bearing only, and had an indwelling catheter (IDC). He had a number of medical problems and was on numerous medications. A referral to the DHB district nursing service was made for the management of Mr A's catheter.[7] A referral was also made to a home help organisation. Their responsibility was limited to personal care and home help only.

26. This report considers the care provided to Mr A during an admission to EPRV's 48-hour complimentary short-term care.

[7] Not yet actioned as at Day 1.

48-hour complimentary short-term care

27. EPRV provided HDC with its "48 hour complimentary short term care for retirement village residents" brochure. The brochure states:

> "In order to help an independent resident who is unwell or convalescing (not acutely or critically ill) we offer a complimentary 48 hour stay in our care centre. This is generally used by independent residents who need a little TLC[8] and routine checks taken of them. It is not used as an extension of respite care."

28. EPRV advised that Mr A and his wife lived at EPRV independently, with only minimal oversight from EPRV. No nursing or medical care is provided to town-house residents, who access their own medical expertise in the same way as any other independent community members.

29. EPRV told HDC that the level of care intended for this service is "minimal" and involves "access to care staff, and oversight from an RN during the day". It added that internal protocols apply to this service, and therefore:

> "There is no regulatory requirement to undertake any paperwork or observations of these residents as the service is totally private and has no alignment with the DHB. No written consent is required."

30. As such, EPRV wished "to make clear that there are significant differences between complimentary care and, for instance, rest-home care and respite care".

Admission on Day 1

31. During the week that followed the hospital discharge, Mr A and his wife struggled to cope at home. On Day 1, the Clinical Manager of EPRV, RN E,[9] met with Mr A and his son, Mr B, to discuss their concerns. RN E said that she reviewed Mr A's needs and offered him "two days [of] complimentary care", which was accepted.

32. RN E told HDC:

> "I advised that I felt that the advantage of [Mr A] being in the village centre [receiving 48 hours of complimentary care] over the weekend was that:
>
> a. The room was more compact and had less obstructions than the town house therefore easier for him to move about using his gutter frame as non-weight bearing.
> b. All meals would be provided, reducing some of his stress …
> c. As [Mr A] would be seen frequently by staff, it would be easier to judge whether a referral back to NASC[10] for an increase in home care would be appropriate.
> d. Staff could reinforce that he was not to weight bear …
> e. Any problems with his catheter would be recognised quickly …
> f. Any necessary interventions/assessments could be undertaken in a more suitable environment than in the town house."

[8] Tender loving care.
[9] RN E is no longer the Clinical Manager at EPRV.
[10] Needs Assessment and Service Coordination.

33. Mr B recalled being told that his father would be receiving complimentary "respite care". However, EPRV explained that there is a difference between respite care and the short-term care that was offered to Mr A. EPRV stated that generally respite care is the placement of a person in an aged-care facility that is organised via the NASC team and is contracted by the district health board. By contrast, Mr A was offered a "private solution".

34. Mr B told HDC:

> "No information was provided to the family as to what services were being provided for the respite care, except that the existing caregiver from [the home help organisation] would continue. No further questions about allocated carer tasks, hours or previous discharge summaries or family concerns were requested by [EPRV]. No informed consent was gained to Respite care service being provided."

35. EPRV told HDC that an information brochure can be provided to residents who are considering the service, but that Mr A did not receive one, and the service was described to him verbally. RN E told HDC that she believed that the discussion she had with Mr A and his son addressed the care that would be provided over the weekend and this was the first time she had failed to provide the complimentary care brochure to a family.

36. EPRV explained that generally the service is provided in the rest home unit but, at the time of Mr A's admission, the rest home was full and therefore he was placed in the serviced apartment building connected to the rest home. As such, EPRV told HDC that Mr A's care fell under the responsibility of the senior caregiving staff rather than a registered nurse. On the other hand, RN E told HDC that she understood that senior caregiving staff in serviced apartments were overseen by a registered nurse and, ultimately, it is the registered nurse who is responsible for the care. RN E also stated that, on reflection, she should have declined support for Mr A when a bed was not available at the rest home, and instead recommended that Mr A go to the hospital.

37. EPRV stated that the decision to place Mr A in the serviced apartment was "a considered one" and "there was no benefit to EPRV in offering [Mr A] this care". RN E was aware that the rest-home unit was full but felt it would be beneficial to have a greater level of care than he was receiving in his town house.

38. At approximately 5pm, Mr A was transferred from his town house to the serviced apartment. RN E explained that she "incorrectly assumed" that no formal admission documentation was required for Mr A because he was an independent resident. Therefore, the only documentation she completed for Mr A was progress notes.

39. RN E stated that she discussed Mr A's needs with the senior caregiver in charge. On a handover sheet, the senior caregiver documented: "[Mr A] — respite [until] Sunday?" RN E said that she also spoke to a hospital nurse,[11] RN G, about Mr A's care and had expected RN G to visit him and provide additional oversight. RN E acknowledged that she did not communicate these intentions to RN G clearly and, as a result, RN G did not attend to Mr A on the evening of Day 1. RN E considered that other contributing factors to the

[11] Hospital registered nurses are located at EPRV's care centre, and can be contacted to provide assistance to serviced apartment residents.

misunderstanding between her and RN G was the lack of documentation around the complimentary care service processes and the placement of Mr A in the serviced apartment, which was unusual.

40. Other than two entries in Mr A's notes from RN E at 2.00pm and 5.00pm and a handover note stating, "[Mr A] — no concerns over the night," there was no further documentation made about Mr A's care on Day 1.

41. RN E told HDC that although she was not working over the next two days, as Clinical Manager she had the responsibility to be on call and to provide advice and assistance to staff at any time. RN E noted that no one contacted her about Mr A's care from Day 1 to Day 3. She said that ultimately she was accountable for the delivery of care at EPRV.

Day 2

42. On the morning of Day 2, Mr A's progress notes document that a serviced apartment caregiver informed the Hospital Coordinator, RN F,[12] that Mr A's catheter was leaking. RN F visited Mr A and documented that his "catheter was leaking at penis [and] insertion site". She then advised Mr A that "he would have to go to [the public hospital] to have a new catheter inserted as [EPRV] were unable to do it for him". RN F explained that when she visited Mr A, she responded as she would for all independent residents. She added that "we do not usually arrange transfers to hospital for independent residents, except in emergencies". RN F stated that she "had no GP instruction or awareness of his catheter management and was there only to assess and advise" him. She added that she was unaware of the reasons for Mr A's admission to short-term care.

43. RN F said that it was her understanding that, as an independent resident, Mr A did not require any documentation, and she was unaware of any policy relating to complimentary short-term care. She stated: "As [Mr A] was admitted to a serviced apartment his care fell under the responsibility of the serviced apartment area …"

44. RN F recalled that Mr A said that he would telephone his son and ask him to take him to hospital. She then left Mr A with the caregiver. EPRV told HDC that the caregiver heard Mr A leave a voicemail message indicating that he needed to be taken to hospital. EPRV stated that the caregiver assumed that the voice message would be received, and therefore informed the serviced apartment senior caregiver that Mr A would be going to hospital with his son. On the handover sheet, the senior caregiver noted that Mr A had "gone with son to hospital re catheter".

45. Mr A's daughter, Ms C, had telephoned Mr A on this day, and he had advised her that he was "waiting for [Mr B]".[13] Mr B, however, stated that he did not receive any messages on his mobile phone or home phone, and expected that staff at EPRV would have contacted him. Mr A's family added that, despite trying a number of times, no one was able to reach Mr A on his mobile phone.

46. At approximately 8pm, Mr A's wife visited him. She advised that no dinner had been offered to Mr A, so she requested a meal for him. EPRV told HDC that the senior caregiver

[12] RN F is no longer the Hospital Coordinator at EPRV.
[13] From meeting notes with EPRV.

in charge believed that Mr A had returned from the hospital, and took him a meal. She then helped him into bed at 9pm. EPRV stated that Mr A did not indicate that he had any issues with his catheter, and the senior caregiver was not alerted to any concerns. EPRV told HDC that Mr A was checked again at 10pm, but there is no documentation of this.

47. EPRV stated that at 10.30pm the serviced apartment senior caregiver went off duty without updating the handover sheet and alerting the team that Mr A was in the serviced apartment.

Day 3

48. At 11am on Day 3, Mr B arrived at EPRV to visit his father. An exchange occurred between Mr B and the senior caregiver in charge where it became clear that the caregiver was unaware that Mr A was still present in the serviced apartment. The caregiver and Mr B went to the serviced apartment, where they found Mr A in a distressed state. Mr A's wife and a caregiver from the home help organisation were also present.

49. EPRV told HDC that Mr A's bed was wet and he had removed his catheter bag. Mr B told HDC that he found his father "in a state of shock; cold confused, dehydrated and in pain". Mr B added that his father was "sitting in shorts only on a urine-stained bed" and "his catheter had leaked all the way through his bed … and had dried from the night before". Mr A had not had any breakfast or cares since the previous night. At Mr B's request, an ambulance was called for Mr A and he was admitted to the public hospital.

Further information — EPRV

50. EPRV told HDC that it has always accepted responsibility for the lack of care provided to Mr A, and acknowledged that there were a number of opportunities for it to react differently and, in particular, to communicate more effectively within the EPRV team as well as with Mr A's family.

51. EPRV also told HDC that it has made comprehensive changes to address the issues highlighted by this incident. It met with Mr A's family and developed a quality improvement plan (QIP), which has now been implemented. The plan includes training to clarify communication expectations, and policies and procedures on admissions to 48-hour complimentary short-term care. In summary:

- A detailed care plan is now completed for all residents, irrespective of their length of stay.
- Progress notes are completed on every shift.
- All complimentary care is undertaken in the rest home.
- Incident forms are completed for every contact between a registered nurse and an independent resident requesting help of any nature.
- Medical history is obtained from a general practitioner or hospital discharge papers prior to admission.
- A registered nurse must speak directly with a family member, and not rely on the resident passing on information.
- Training has been undertaken with staff about the importance of accurate information being updated in the handover books to ensure that communication between shifts is current and accurate.

52. EPRV added that processes have now been put in place to help ensure that families using complimentary care are provided with the informational brochure.

Further information — RN E

53. RN E stated that she knows that no apology will excuse the fact that Mr A's care was compromised because of her and her team's poor communication. RN E told HDC that she visited Mr A whilst he was in hospital to apologise personally for the lack of care he had received.

Further information — RN F

54. RN F stated that she is genuinely sorry, and apologises for the distress caused. She advised that she regrets not following up to ensure that Mr A had been taken to hospital by his family.

55. RN F told HDC that she has since attended further training and understands that:

- Health issues must be communicated directly to a family member, and contact with the next of kin must be persevered until someone can be reached.
- The handover book must be updated with accurate information to ensure that communication between shifts is current and accurate.
- Progress notes are to be kept up to date for all residents on 48-hour complimentary care.

Relevant policies

56. EPRV told HDC that "there were two internal [company] protocols that were fundamental to guiding the decision-making process and care that [Mr A] should have received". The first is the "Independent Apartments and Townhouses — Temporary Assistance" ("Temporary Assistance") policy, which states:

> "If an independent resident urgently requires overnight care they are given priority access to the resthome/hospital, and there is no charge for a stay of up to 48 hours.
>
> If no room is available in the resthome/hospital the Manager will attempt to provide support to the independent unit if appropriate …
>
> Any changes to the circumstances of an independent resident should be recorded in the movements book, and admission agreements should be completed for a stay of more than 48 hours …
>
> The resident should be given a copy of 48 Hour Complimentary Short Term Care for [Retirement Village] Residents."

57. The second is the "Short Term Care — Admission, Clinical Documentation and Discharge" ("Short Term Care") policy. It states:

> "**Policy**
> To provide well coordinated, high quality care and service to short-term residential care residents that promotes the residents' ability to return to their home after an episode of care.

This policy is to be read in conjunction with Admission Procedure and provides additional detail around the process for short term care admissions.

Procedure

Preparation prior to the resident arriving

- Baseline information regarding the resident's health, abilities and support needs will be collected from Needs Coordination and/or family and/or other relevant sources and will be retained and updated on each admission.
- NASC or other funding documentation will be provided to the facility and an admission agreement signed.
- Family will be provided with a copy of the short-term admission welcome booklet.
- Transport will be planned with the carer to facilitate the resident's admission and discharge for respite care. The facility will provide transport as required.
- A Short Term Care Checklist will be commenced for all short term care residents prior to admission.

Once the resident arrives

- The village manager will meet and greet short term residents and their families, and follow-up with daily visits throughout the stay wherever possible.
- The clinical manager or coordinator will provide daily oversight of all short term residents.
- Continuity of care will be provided for each resident's admission by retaining the same RN and primary nursing group wherever possible.
- If the admission is within six months of the last admission, the previous care plan can be reviewed, updated and implemented.
- The resident will bring with them into the facility all aids to daily living that have been issued to maintain their maximum function in the community.

During their stay

- Daily clinical monitoring of short term care residents will be provided by the clinical manager/RN coordinator and clinical records will be maintained with at least daily entry by the RN.
- Regular communication with the resident's next of kin will be maintained throughout the short term admission as agreed in the admission planning with the resident's next of kin.
- Each short term care resident will be assessed by the RN and will receive physiotherapy and occupational therapy as required to maintain their maximum function (hospital).
- The resident's GP will be responsible for their health needs and medical treatments during admission for care unless this is delegated to the facility's house doctor.
- Decisions relating to any change of treatment or support needs will involve the primary RN, the resident's GP and the support services co-ordinator.
- Short term care residents will be discussed at the weekly management meeting with specific reference to their clinical condition, how they are settling in, and discharge planning.
- The clinical manager/RN coordinator will maintain close liaison with the service co-ordinator for each resident to ensure the allocated days of respite care are

adhered to and to provide information relating to the support needs assessed during respite care."

58. The Admission Procedure referred to in the above policy relates to the admission of new residents to EPRV.

Responses to provisional opinion

Mr A's family

59. Mr A's family were provided with an opportunity to comment on the "information gathered during investigation" section of the provisional opinion. Mr A's family did not provide any comment.

EPRV

60. EPRV was provided with an opportunity to comment on the provisional opinion. Its comments have been incorporated into this report. EPRV told HDC that it "understands and fully accepts that the care provided to [Mr A] did not meet the standard of care usually provided by EPRV" and was "sub-optimal". EPRV reported that it "has taken this incident very seriously and made significant changes throughout all of its New Zealand villages to ensure that a similar situation does not arise in the future".

61. EPRV told HDC that it has completed all the recommendations contained in the provisional report, except for providing a written apology to Mr A's family.

RN E

62. RN E was provided with an opportunity to comment on the relevant sections of the provisional opinion as it related to her. Her comments have been incorporated into this report. RN E told HDC that she "accepts the findings made by the Commissioner" and "accepts that her involvement in the care provided to Mr A was not to the required standard".

63. RN E told HDC that all of the recommendations contained in the provisional report have been undertaken except for the written apology.

RN F

64. RN F was provided with an opportunity to comment on the relevant sections of the provisional opinion as it related to her. Her response has been incorporated into this report.

Opinion: Evelyn Page Retirement Village Limited — breach

65. As a provider offering short-term care to elderly residents who may be unwell or convalescing, EPRV has overall responsibility for providing these services with reasonable care and skill. It needs to have in place adequate systems, policies, and procedures, and to ensure compliance with those policies and procedures, so that the care provided is appropriate.

66. EPRV has noted that there are "no regulatory requirements" that apply to this service, as it is a "private arrangement" and internal protocols apply. My expert advisor, RN Jan Grant, advised that irrespective of whether EPRV was providing private short-term care or publicly funded respite care, this should not have affected the desired positive outcome that Mr A and his family expected when they accepted the service. I agree, and note that the rights set out in the Code of Health and Disability Services Consumers' Rights (the Code) apply regardless of how the service is funded. I consider that EPRV failed to provide Mr A with the appropriate standard of care in a number of ways.

EPRV's policies and procedures

67. RN Grant advised that EPRV needs to "clarify and clearly document their responsibility/policies/procedures in relation to short term stays for [independent] residents". In my view, EPRV's policies and procedures do not provide sufficient clarity around the admission process, clinical oversight of short-term care residents, and documentation.

Admission

68. RN Grant advised that it was appropriate to admit Mr A for extra support and care, but considered that the admission process was inadequate. RN Grant advised:

> "I believe the process should have been:
>
> - To confirm and define with staff from Evelyn Page and with [Mr A] and his family the various responsibilities for his care prior to his admission to the residential facility.
> - To have appropriate documentation, including a consent form.
> - To have a short term care plan for [Mr A's] admission to outline cares and goals for the duration of his stay.
> - To have a review plan in place should the respite care plan not meet [Mr A's] needs.
>
> Once the facility accepted [Mr A] in care, then there was a responsibility to provide a level of care that supported and improved his health status."

69. I agree. The Short Term Care policy states that it is to be read in conjunction with the Admission Procedure. However, the Admission Procedure relates only to the admission of new residents. There is no specific policy around the steps that should be taken by staff when offering complimentary care and admitting an existing resident to the service.

70. It is EPRV's responsibility to set clear expectations around the steps staff should take when offering and admitting a resident to complimentary short-term care. I do not consider that EPRV has fulfilled this responsibility.

Clinical oversight

71. RN Grant stated that there is no documentation outlining responsibilities in relation to who was to provide care and support to Mr A.

72. The Short Term Care policy appears to consider that the resident will receive seamless nursing care, and states that the resident will retain the same registered nurse and primary nursing group. In addition, the policy states that daily clinical monitoring will be provided

by the Clinical Manager/RN Coordinator, and that clinical records will be maintained at least daily by the registered nurse.

73. I note that it was RN E's intention to place Mr A in the rest home area for his complimentary short-term care and, given that she spoke to RN G about Mr A's cares, that she envisioned Mr A receiving some nursing care. However, as there were no available beds at the rest home, Mr A was placed in a serviced apartment. As such, EPRV told HDC that his care fell under the responsibility of the senior caregiving staff. The Hospital Coordinator, RN F, who attended on Day 2, appeared to have no knowledge of the reasons for Mr A's admission; nor does her response to HDC indicate that she considered herself responsible for his care.

74. It is unclear to me whether the nursing or the caregiving staff were responsible for Mr A's care. In my view, placing Mr A in a serviced apartment instead of the rest home as intended gave rise to uncertainty, and this arrangement compromised his care. If caregiving staff can at times be responsible for complimentary short-term care residents, this needs to be reflected in EPRV's policies, and properly communicated to those staff. I also note that RN E acknowledges that she did not clearly communicate her expectations about Mr A's care to RN G. Because of the poor communication and lack of documentation, Mr A's arrangement was confusing and disorganised, and the care provided to him lacked the appropriate clinical oversight.

Documentation

75. RN Grant noted that there was inadequate care planning and documentation. She advised that "documentation was not of [an] acceptable standard that would be expected for any patient/resident in a care facility". RN Grant considered that once Mr A was accepted into care, "the organisation had a responsibility to provide and document assessment and cares". RN Grant advised that the clinical documentation included two pages of brief notes, and lacked the detail that was required to care for Mr A.

76. The Short Term Care policy anticipates documentation being carried out for short-term care residents. It also states that an admission agreement will be signed. In contrast to this, the Temporary Assistance policy states that an admission agreement is not required unless the resident stays for longer than 48 hours. I note that RN E (a senior staff member) was under the mistaken belief that no formal admission documentation was required for Mr A. RN F similarly understood that documentation was not required for independent residents.

77. I am critical that EPRV does not appear to have consistent policies on documentation requirements for short-term care residents. In this context, it is unsurprising that staff at EPRV lacked sufficient knowledge about the issue.

Communication

78. RN Grant advised that communication was inadequate, and noted that there is no evidence that the type of care the facility would provide was communicated to the family.

79. I agree that communication with Mr A and his family was poor, and information about what the service would entail was not provided adequately. I note that all discussions about the service were verbal, and that the Temporary Assistance policy does not require the Clinical Manager to provide a brochure to the resident.

80. It would be prudent for EPRV to provide written confirmation of the service it is providing, and I am critical that Mr A did not receive this. In any case, I consider the current brochure to be flawed for the following reasons:

- The term "TLC' is vague and is open to interpretation.
- It is unclear who will complete "routine checks" of the resident.
- Most of the brochure discusses the financial aspects of the service rather than what care it will be providing.

81. In my view, the brochure should provide more clarity to residents and their families and more adequately define the service being offered. This would also assist staff to communicate more effectively about the service.

Conclusion

82. RN Grant concluded that the care and support that was provided to Mr A would be viewed as a "severe departure from acceptable standards" by her peers. She considered the main reasons for this departure to be inadequate communication and lack of documentation. In RN Grant's opinion, "the fault lies at an individual level as well as at an organisational level".

83. Whilst I note that EPRV has advised that the policies are used as a "guide", it is unclear to me which aspects of the policy apply as a guide and which do not. It is also concerning that EPRV staff were either unclear about, or entirely unaware of, the policies relating to complimentary care.

84. If EPRV is to offer complimentary short-term care to residents who are elderly and unwell, it must ensure that it has adequately clear and robust internal policies and procedures in relation to such a service. For the reasons outlined above, it is my view that EPRV does not have adequate policies and procedures in place for the delivery of complimentary short-term care to independent residents. It therefore failed to guide its staff to deliver the service in an appropriate and safe way. In addition, EPRV failed to communicate adequately regarding the service that was being offered to Mr A. Overall, I consider that EPRV did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Opinion: RN E — breach

Standard of care

85. As Clinical Manager, ultimately RN E was accountable for the delivery of Mr A's care when she admitted him to complimentary short-term care on Day 1.

86. RN Grant advised that the assessment and admission process was the responsibility of the Clinical Manager. She noted that RN E had documented that Mr A was admitted for "TLC", but there was no information in relation to his mobility, personal hygiene, or dressing and grooming. RN Grant noted that Mr A was touch weight-bearing and thus required

additional assistance to remain safe. There was also no mention of his other medical problems, in particular the management of his anticoagulation status, diabetes, and constipation. There was also no information in relation to his medication, and who would be responsible for this.

87. RN Grant stated that she would have expected RN E to have implemented a short-term care plan outlining staff and family responsibilities. The care plan should have identified goals for Mr A's stay and the interventions necessary to meet these goals. RN Grant considered that the brief documentation "lacked the detail that would be required to provide an appropriate level of care to [Mr A]".

88. RN Grant also noted that the admission entry stated that Mr A was "having problems with IDC (catheter) and constipation", but that there was no explanation about what the problems were, and nothing on record to describe whether the IDC was patent and draining, the concentration of the urine, or whether Mr A was able to care for his IDC himself. There was no mention of fluid intake or catheter cares that would be required during his stay. RN Grant concluded that Mr A's overall standard of care and support, including his catheter management, was a "severe departure" from accepted standards, and noted that some of the fault "lies at an individual level".

89. As Clinical Manager, RN E's management of Mr A's admission on Day 1 is concerning. She failed to assess Mr A adequately and to document his needs at admission adequately. She also did not have the requisite knowledge of EPRV policies and procedures around complimentary short-term care, yet was responsible for offering the service to residents. In my view, RN E did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Communication — adverse comment

90. RN Grant advised that communication was inadequate, and noted that there is no evidence that the type of care the facility was to provide to Mr A was communicated to the family.

91. I agree that RN E's communication with the family appears poor, and the family did not receive adequate information about what the service would entail. RN E's and Mr B's recollections of their conversation do not indicate that the level of care and who would be providing it was discussed. RN E's communication with RN G was also poor. Evidently, there was a breakdown in communication between RN E and RN G, resulting in RN G not providing Mr A with extra support upon admission as intended. Both conversations appear to have lacked clarity, and substantial reflection on the importance of effective communication is required from RN E.

Opinion: RN F — breach

92. RN F attended Mr A on Day 2 after being informed that his catheter was leaking.

93. Other than documenting that the "catheter was leaking at penis [and] insertion site", no other assessments were carried out. RN Grant advised that there was "no documentation as

to the amount of leakage, the amount of urine output in the catheter bag or the concentration and appearance of the urine (for example the presence of haematuria)". She stated that RN F did not document that the abdomen was examined for discomfort or palpable bladder, to rule out the presence of urinary retention. RN Grant concluded that the care of Mr A's indwelling catheter was a "severe departure" from acceptable standards.

94. RN Grant also considered that telling an unwell 84-year-old man to arrange his own admission to the public hospital "was inappropriate and unprofessional". She considered that as Mr A had been admitted to short-term care, EPRV should have facilitated, arranged, and supervised Mr A's transfer to hospital. It was also the facility's responsibility to communicate personally with Mr A's wife and son, and not leave this up to a frail and unwell man.

95. RN F told HDC that she was unaware of the reasons for Mr A's admission to short-term care, and responded to him as she did with all independent residents. She understood that as Mr A was in a serviced apartment, his care fell under the responsibility of the senior caregiving staff.

96. Whilst I acknowledge that Mr A's arrangement created ambiguity around who had clinical oversight of him, the clinical picture that Mr A presented to RN F (a leaking catheter) was clear, and should have triggered an adequate assessment of Mr A with the requisite examinations as outlined by RN Grant. I am also concerned about RN F's advice to Mr A to arrange his own admission to the public hospital. To me, this demonstrated a lack of care, and was inappropriate. Accordingly, I find that RN F did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Recommendations

97. I recommend that EPRV:

a) Provide a written letter of apology to Mr A's family for its breach of the Code. The apology should be provided to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Provide HDC with evidence that RN E and RN F have received the relevant training on EPRV's policies and procedures for 48-hour complimentary care. EPRV is to provide this to HDC within three months of the date of this report.

c) Provide HDC with evidence that the changes already made to the 48-hour complimentary care have been reflected in current policies and procedures. EPRV is to provide this to HDC within three months of the date of this report.

d) Provide HDC with evidence that it has reviewed its "48 hour complimentary short term care for retirement village residents" brochure and provide HDC with the outcome of this review within three months of the date of this report.

e) Provide HDC with evidence that it has developed a specific policy for its 48-hour complimentary care service. The policy should provide clear guidelines on admission processes, communication with the resident and his or her family, clinical responsibility, and documentation. EPRV is to provide a copy of the policy to HDC within six months of the date of this report.

f) Provide HDC with evidence that it has audited, over a period of six months, the standard of staff documentation for residents admitted to 48-hour complimentary care, and provide HDC with the outcome of the audit within six months of the date of this report.

98. I recommend that RN E:

a) Provide HDC with evidence that she has undertaken further education on the principles and requirements of admission and care planning in aged care, and provide evidence of this within three months of the date of this report.

b) Provide HDC with evidence that she has undertaken training on effective communication, and provide evidence of this within three months of the date of this report.

c) Provide a written letter of apology to Mr A's family for her breach of the Code. The apology should be provided to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

99. I recommend that RN F:

a) Carry out a reflective practice case study on the care she provided to Mr A, and provide HDC with a copy of her report within three months of the date of this report.

b) Undertake further education and/or training on indwelling catheter management, and provide evidence of this within three months of the date of this report.

c) Provide a written letter of apology to Mr A's family for her breach of the Code. The apology should be provided to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

100. I recommend that the Ministry of Health consider whether the learnings from Mr A's experience and my investigation could be applied to the wider aged care sector. In particular, the responsibilities of providers when offering services such as complimentary short term care.

Follow-up actions

101. EPRV will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994, for the purpose of deciding whether any proceedings should be taken.

102. A copy of this report with details identifying the parties removed, except the expert who advised on this case and EPRV, will be sent to the DHB, the Health Quality and Safety Commission, and the Ministry of Health (HealthCERT). The DHB will be advised the name of RN E and RN F.

103. A copy of this report with details identifying the parties removed, except the expert who advised on this case and EPRV, will be sent to the Nursing Council of New Zealand, and it will be advised of RN E and RN F's name.

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

Addendum

105. The Director of Proceedings filed proceedings by consent against EPRV in the Human Rights Review Tribunal. The Tribunal issued a declaration that EPRV breached Right 4(1) of the Code by failing to provide services to Mr A with reasonable care and skill.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Jan Grant:

"I have been asked to provide an opinion on the care provided to [Mr A] by Evelyn Page Retirement Village [(EPRV)].

I have no personal or professional conflict of interest in the case. My advice is based on a review of the documentation provided.

I have read and agreed to the Commissioner's guidelines.

I am a Registered Nurse with 30 years of experience in Aged and Community Care. In that time I have had a variety of roles. I have represented NZNO and the Aged Care Sector on a number of national working parties. I have been involved in setting Standards for Practice for Gerontology Standards. I have been a clinical tutor and guest speaker both here in New Zealand and overseas. I have had international papers published. My immediate past role was as Clinical Advisor/Rehabilitation Coordinator in the community. I am a designated assessor for ACC.

Documents reviewed

- Letter of complaint
- EPRV's response
- Family feedback
- Phone note from HealthCERT
- Further response from EPRV dated 24 November 2016
- Clinical records from EPRV
- Clinical records from [the public hospital]

Background

[Mr A] was admitted to [the public hospital] [in] 2016 with a pathological fracture of the right neck of femur. He was discharged from [the public hospital] [a few weeks later].

At the time of discharge he had an indwelling catheter.

[Mr A's] listed medical problems included:

- Atrial Fibrillation, anticoagulated on warfarin
- Type II Diabetes on metformin
- Prostate cancer
- Permanent IDC in situ
- Paget's disease
- IHD, CABG in 1994
- Thrombocytopenia
- Polymyalgia rheumatica, on steroids
- Previous left Total hip joint replacement in 2007

He was discharged from [the public hospital] on 14 different medications. His discharge letter stated that he was offered interim care for his recovery but that he declined this because of his preference to reside in the same residential facility as his wife. Prior to his [public hospital] admission, [Mr A] and his wife were living independently in a unit in the EPRV.

He was discharged home with what appeared to be one hour of home support per day. Available information indicated that [Mr A] had required a long period of rehabilitation during his admission to [the public hospital]. At the time of discharge he was touch only weight bearing. He was provided with a support package of one hour of home support daily to assist with ADLs.

The family struggled to cope at home over the next week and were offered Respite/Complimentary care for 48 hours by the EPRV staff.

Staff from EPRV attended [Mr A] in his unit three times in the week following his discharge, to assist with flushing his catheter. EPRV decided that should the RN need to assist with catheter care, having [Mr A] in a serviced apartment would make this task easier.

[Mr A] was thus admitted into care at EPRV on [Day 1] — a Friday afternoon.

Questions

1. The standard of care provided to [Mr A] during the 48 hour complimentary care

From the documentation provided, two pages outline the cares and communication.

The first notes relate to the admission:

'[Day 1]: 1400 [Mr A] discharged from [the public hospital] earlier this week. Has been having problems with IDC and constipation. Admitted to SA326 for TLC over the weekend. Will come over about 1700hrs — needs toilet raiser and shower stool — same taken to apt. 1700 […] went over to TH9 to collect [Mr A] and taken up to SA325. Requires extra cushions as chairs too low for him to get up unaided. Also requested extra pillows for bed. Extra cushions and pillows provided. Evening meal sent up for [Mr A] and [his wife] to have in room. [RN G] made aware that [Mr A] is in apt.

signed [RN E] (Clinical Nursing Coordinator)'

The second note:

'[Day 2] in am: Caregiver came to me to advise me that [Mr A's] catheter was leaking. I went with caregiver to see [Mr A] — checked yes catheter was leaking at penis and insertion site. Asked [Mr A] how long this catheter had been in — he said 3 weeks — I advised him he would have to go to [the public hospital] to have a new catheter inserted as we unable to do it for him at EPRV as we require Dr's permission. Asked caregiver and [Mr A] to contact his son to take him to the hospital. (unable to read signature)'

The third note:

'*[Day 2]*: *During morning cares the caregiver that was doing [Mr A's] cares informed me that [Mr A] was going to hospital with his son due to his catheter problems. At 8 at night his wife came and saw me concerned that he had not received a dinner meal so I gave one to him. At 9pm I helped him to bed. (unable to read signature)'*

No other documentation was available.

Family visited the next morning on the [Day 3]. His son [Mr B] went to enquire how cares had gone overnight. Staff appeared to be unaware that [Mr A] was still in the facility. At around 1030am he was visited by his wife and the caregiver from the homecare agency. He was found to be (as the family describe) cold, confused, dehydrated, in pain and in a urine-stained bed.

He was not able to reach the call bell or water. He had received no cares since the evening before. At this time an ambulance was contacted and [Mr A] was admitted to [the public hospital].

The initial notes of [Mr A's] stay in the residential facility state he was to receive TLC (tender loving care) over the weekend. These notes were written by the clinical coordinator and in some way list what was required in the way of equipment. However, they in no way list the support in relation to nursing cares that [Mr A] required. In addition there is no documentation outlining responsibilities in relation to who is to provide the care and support. There is also no evidence that the type of care the facility would provide was communicated to the family. A home care package had been provided at the time of his discharge from [the public hospital] for one hour each morning on a daily basis.

My assumption is that this was for showering, dressing etc, and that it was to continue while [Mr A] was in the rest home.

It would be a reasonable expectation from the family, however, that if [Mr A] was going into care as they were not coping at home, then the staff at the facility would provide the care and attention needed to keep [Mr A] safe and well. It would also be reasonable for the family to assume that if [Mr A] had any medical issues then these would be addressed and documented by the nursing staff, discussed with the family, and dealt with appropriately.

If they were unable to do this due to [Mr A's] high needs then I believe staff had a responsibility to immediately refer him back to hospital and keep family informed and involved in the process.

I would expect that a short term care plan outlining staff/family responsibilities be documented by the clinical coordinator on admission. This would not have to be a long, full nursing care plan but the documentation should certainly have identified the goals for his stay and the interventions necessary to meet these goals. This should have been undertaken on admission. EPRV staff should have also had a copy of the discharge letter from [the public hospital]. This would have provided important information into

[Mr A's] medical issues and would have thus assisted in the development of an appropriate plan of care.

For example:

[Mr A], at the time of his discharge, was touch weight bearing only. This indicates that he would need assistance for most ADLs requiring him to stand/walk. It also suggests he would be at risk of falls if left unsupervised for any length of time.

It was noted that [Mr A's] catheter was leaking and that he was constipated. It is quite possible the constipation was contributing to the catheter leakage and yet there is no documented evidence that this issue was assessed and that any plan was put in place to remedy the problem.

He was a type 2 diabetic on metformin but there is no documented evidence that there was any monitoring of appropriate food and fluid intake and blood glucose levels.

I believe the process should have been:

- To confirm and define with staff from EPRV and with [Mr A] and his family the various responsibilities for his care prior to his admission to the residential facility.
- To have appropriate documentation, including a consent form.
- To have a short term care plan for [Mr A's] admission to outline cares and goals for the duration of his stay.
- To have a review plan in place should the respite care plan not meet [Mr A's] needs.

I believe that once the facility accepted [Mr A] in care, albeit for 48 hours, then there was a responsibility to provide a level of care that supported and improved his health status.

The clinical notes indicate that staff knew of his IDC issues and constipation, but there was no other information in relation to anything else. When [Mr A's] IDC blocked, advice was given to him to arrange to get himself admitted to [the public hospital]. This advice in the context of telling an 84 year old unwell man was inappropriate and unprofessional. A letter from EPRV indicates that staff remained with [Mr A] while he phoned his son but in statements from the family, his son never received the message and hence a transfer to [the public hospital] did not happen.

I am of the opinion that by accepting [Mr A] into care then the facility had a level of responsibility to facilitate, arrange and supervise the transfer. It was also their responsibility to personally communicate with [Mr A's] wife and son and not to leave this complicated process up to a frail and unwell older man.

If the wife had not visited later in the day then one can assume that [Mr A] would not have received care from midday on [Day 2] until he was found the next morning. It was only when she visited that staff realised he was still at EPRV. Following the evening visit for dinner no notes were made and hence no care or support was given to [Mr A] overnight until he was found by family the next morning.

Written communication should have been completed each shift.

Summary

I am of the opinion that the care provided was not of an acceptable standard in relation to:

- Documentation
- Support and nursing cares
- Medication support and clarity
- Seeking medical advice re IDC cares
- Communication with family

I believe that the overall standard of care and support given to [Mr A] would be viewed as a severe departure from acceptable standards by my peers.

2. The management of [Mr A's] indwelling catheter and the appropriateness of advice given to him.

The admission entry written by the clinical coordinator states the [Mr A] was *'having problems with IDC and constipation'*. There is no explanation as to what the problems are. There is nothing on record to describe if the IDC was patent and draining, the concentration of the urine or even if [Mr A] was able to care for his IDC himself or would need assistance. There is no mention of fluid intake or catheter cares that would be required during his stay.

The second entry documented by an RN on [Day 2] states that the caregiver reported that [Mr A's] IDC was leaking from around the insertion site. [Mr A] stated that the present IDC had been in situ for three weeks.

There is no documentation as to the amount of leakage, the amount of urine output in the catheter bag or the concentration and appearance of the urine (for example presence of haematuria). There is no documentation the abdomen was examined for discomfort or palpable bladder, to rule out the presence of urinary retention. In addition there is no documentation that the nature and severity of the constipation was assessed by clinical examination. The advice was to ask the caregiver to ask [Mr A] to ring his son and arrange admission to [the public hospital] for a change of catheter.

The second entry on [Day 2] does not document any IDC issues except to state that the staff member thought [Mr A] was going to hospital. Therefore it is not apparent at this point if the catheter continued to be leaking/blocked.

The notes do not indicate that any IDC cares such as changing bags, recording of urine output and fluid intake was being done by staff, or if [Mr A], was at this point, attempting to be self-caring.

Summary

Documentation provided by [EPRV] indicates that staff had attended to [Mr A] three times when he returned home following surgery at [the public hospital]. The report also states that:

'*[Mr A] could come across to a serviced apartment for the weekend so staff could observe him as he was having problems with his catheter'*

I am of the opinion that [Mr A] was admitted for supervision and cares in relation to his IDC.

I am of the opinion that the care for [Mr A's] indwelling catheter cares was not of an acceptable standard. I believe this departure from acceptable standards would be viewed as a severe departure by my peers.

3. The adequacy of the clinical documentation

Clinical documentation includes 2 pages of brief notes written on 3 separate occasions once before admission and then added to following admission on the [Day 1]. There are two separate entries on the [Day 2].

The brief documentation presented lacks the detail that would be required to provide an appropriate level of care for [Mr A]. The initial entries identified what equipment would be required, but did not take into account that he was supposed to be touch weight bearing only and would thus require additional assistance to remain safe.

The notes indicate that [Mr A] was admitted for 'TLC' over the weekend. There was no information in relation to his mobility, personal hygiene, dressing and grooming. There is also no mention of his other medical problems, in particular the management of his anticoagulation status, diabetes and constipation.

There was no information in relation to medications and who would be responsible for these. If [Mr A] was self-administering his medications then a note should have been made of this. Staff should have been asked to ensure that he was able to comply with this task accurately. If his wife was expected to give his medications then this should have been documented and staff should have communicated with [Mr A's wife] to ensure this expectation was met. If staff were administering medications then these should have been in blister packs. The medications that [Mr A] was discharged with were important for him to have on a regular basis. They included medications for his various medical conditions as well as for pain relief. At the very least the steroids, metformin and warfarin intake should have been accurately monitored. There is no evidence that [Mr A] had any of his medications while he was at EPRV and to uphold this, the documentation at the time of [Mr A's re-admission to the public hospital] indicates the possibility that he had not taken his routine medications for the last few days.

Summary

I am of the opinion that the documentation was not of an acceptable standard that would be expected for any patient/resident in a care facility.

4. Any other matters in this case that warrants your comment.

I have been asked by the HDC to looks at 2 different scenarios.

Scenario One
In the event that this care was considered respite care:
I am of the view that the family genuinely believed [Mr A] was to receive respite care and so my opinion is that the care he received was a severe departure from acceptable standards for the reasons stated in my report.

A rest home bed would in my opinion have been the very least level of care that [Mr A] needed. It should have been recognised, however, that he was a high risk patient and I am of the opinion that he needed regular review, with the option to readmit to [the public hospital] if his condition deteriorated in any way. I have seen documentation from HealthCERT indicating that if [Mr A] was in a licensed bed then it would be expected that the Health and Disability Sector standards would apply. I am also assuming that the standards and contractual arrangements with the local DHB would apply.

Scenario Two

In the event that [Mr A] was admitted for 48 hour Complimentary short term care as indicated by EPRV, I do not believe that, taking into account his medical problems, mobility issues, and problems associated with the management of his IDC, that this type of care would have been appropriate.

I agree with the view of EPRV, as documented in the investigation report, that [Mr A's] health was compromised following his admission in March 2016.

It is obvious from the discharge summary when [Mr A] left hospital following his hip surgery, that he needed more personalised care. It is completely understandable that his wife was not able to provide this level of care he needed, at home. One hour of home care, in my opinion, would not have been nearly enough to care safely for this man, especially taking into account his inability to properly weight bear, his IDC problems and his other medical issues. Family have documented how stressful it was.

(It is noted in the discharge letter that it was [Mr A's] choice to be discharged home.)

That being said I believe from the documentation viewed in relation to his admission on the [Day 3], that his health was compromised by not having adequate care and support for the 2 days he was at the EPRV residential facility. It would be a medical opinion as to whether the decline in his health was permanent or not.

I believe that EPRV need to:

- Clarify and clearly document their responsibilities/policies/procedures in relation to short term stays for village residents.
- Confirm and document that family understand the difference between respite and complimentary care.
- Ensure when residents are admitted for complimentary care that all relevant information and documentation (eg discharge letters) is provided by the families/residents.

- Ensure that staff are educated to achieve the skills to make appropriate clinical decisions for each case scenario that presents.

Jan Grant"

The following further expert advice was obtained from RN Jan Grant:

"I have been asked to provide further expert advice to the Commissioner in relation to the care provided to [Mr A] by EPRV.

Further additional information that was provided included:

- Further response from EPRV dated 26th July 2017
- Letter from HealthCERT dated 27th July 2017
- Letter from [home help organisation] dated 28th July 2017
- Letter from [the DHB] dated 26th July 2017

Questions

1. Whether any of the additional information provided causes you to make further comment or amend your original advice. If so please explain why?
Having read the additional information I have not changed my opinion of the overall care and support provided to [Mr A]. It is noted from the response from HealthCERT on the 27th July 2017 that *'[The facility owner] is offering 48 hours complimentary care for independent residents at EPRV in the rest home unit or, if full, then in a serviced apartment also certified for rest home care'.*

As previously stated, I am of the opinion that by offering and arranging 48 hours of care, then EPRV had a professional responsibility to:

- communicate the nature of the proposed care with the family
- plan and provide the care for [Mr A]
- document the planned cares and supports provided to [Mr A].

It is noted throughout this event that both parties, namely EPRV and [Mr A's] family, dispute what the nature of the care was. I do not believe that this should affect the desired positive outcome that [Mr A] and his family expected.

2. Please comment on Clinical Manager [RN E's] decision to offer [Mr A] '48 hour complimentary care'.
From the documentation it was obvious that [Mr A] had a number of challenges at home, following his discharge from public hospital. His IDC had leaked and he had been given support from the nursing staff on 3 separate occasions. However, no documentation was presented in relation to the support that was given.

On 1st April [RN E], the Clinical Manager, assessed that [Mr A] would benefit from 48 hours of complimentary care/respite care. Hence he was admitted on the [Day 1].

My opinion is that it was appropriate to admit [Mr A] for extra support and care. However, by suggesting the admission I believe that EPRV had a clinical responsibility to ensure that [Mr A] received the type of care needed. If this proved to be outside their

scope, then appropriate referral and transfers to another provider or public hospital should have occurred.

3. You have identified a severe departure in the overall standard of care and support given to [Mr A]. Please advise if your criticisms are made on a facility and/or individual level

It is my opinion that fault lies at an individual level as well as at an organisational level.

I am of the opinion that the assessment process and admission was the responsibility of the Clinical Manager. As previously stated there were a number of clinical issues that should have been identified, but were not. The documentation on admission was written at 1400hrs and [Mr A] arrived at 1700hrs. The documentation shows that [Mr A] was admitted at 1700hrs. Information provided only lists his requirements in relation to equipment, e.g. additional cushions/pillows for the chair, and also provision of a meal. My previous advice outlines what should have occurred at the time of his admission.

In her response (addendum 4) [RN E] states that *'the advantage of having [Mr A] in the main building would allow the staff the opportunity to fully assess the situation and to respond promptly to any problems. It would also allow for any interventions to be undertaken in a more suitable environment'.*

As previously stated these outcomes did not happen. The main reasons for this departure were inadequate communication and lack of documentation.

In relation to the organisational responsibility, the organisation's original letter from [EPRV] to the Health and Disability Commission (no date) states:

'*There is no regulatory requirement to undertake any paperwork or observations of these residents as the service is totally private and has no alignment with the DHB.'*

I believe that if short term care, in whatever form, is offered to a client, then the organisation has a responsibility to ensure that the care is delivered appropriately and in the best interests of the client.

In saying that the organisation has no regulatory requirement to undertake any assessment, observations or documentation, there seems little point in an organisation accepting clients who are frail and in need of support, as accurate assessments, instructions and appropriate documentation are all vital in ensuring continuity of care and support.

4. You have identified a 'severe departure' in the care for [Mr A's] indwelling catheter. Please advise if the criticisms are made on a facility and/or individual level

Following [Mr A's] discharge home his IDC leaked 3 times. No documentation was available to state what interventions occurred when he was visited by staff from EPRV. Following his admission to EPRV the care giver advised the RN that [Mr A's] IDC was leaking and she visited and noted that it was leaking around his penis. As previously stated there was no other assessment. The caregiver was advised to instruct [Mr A] to contact his family to arrange a visit to a public hospital to get his IDC changed. I am of the opinion that the registered nurse did not record or carry out any assessment once

she found the IDC leaking. I believe the departure from acceptable standards is on an individual level both from admission and from the visit from the registered nurse of the morning of [Day 2].

5. You have identified a 'severe departure' in the standards of documentation. Please advise whether your criticisms are made on a facility and/or individual level.
I am of the opinion that the documentation was not of acceptable practice as previously stated. Once accepting [Mr A] into care, whether it was respite as the family believed or into complimentary care, then the organisation had a responsibility to provide and document assessment and cares. My original advice states that the documentation lacked the detail that would be required to care for [Mr A]. As previously stated there was no information in relation to mobility, personal hygiene, dressing and grooming. There was no mention of medications being self-administered or supervised by staff. There is no mention of other medical issues which would have been easily identifiable from the DHB discharge letter.

I believe the fault lies at both an individual level with the clinical manager and ongoing staff who were involved with [Mr A's] care, as well as at an organisation level.

The organisation's original letter to HDC (no date) states:

'*There is no regulatory requirement to undertake any paperwork or observations of these residents as the service is totally private and has no alignment with the DHB.'*

[Mr A's DHB discharge letter] clearly states his multiple medical problems, the issues with mobility and the various medications that [Mr A] was on. I am of the opinion that if EPRV accepts a patient such as [Mr A] then it must provide the care and support needed.

6. Please advise whether the severe departures you have identified apply only if the commissioner makes a finding that respite care was provided, or whether the departures still have application in the 48 hours complimentary care context.
I believe that by accepting [Mr A] into care whether it was 'complimentary care' or, as the family assumed, 'respite care' I am of the opinion that the departures from acceptable standards still apply.

There appears to be confusion from clinical staff as the duty handover sheet written by staff states that [Mr A] — 'respite till Sunday'.

The documentation from the discharge letter and the fact that over the week that [Mr A] was at home he required support from trained staff shows that he was very frail. His IDC continued to leak and he was unable to be supported by his wife and the daily one hour of home care he received. It must be also noted that staff at the DHB had offered interim care, recognising he was frail and needing a high level of care. However, this was declined due to his preference to be near his wife.

Accepting [Mr A] into either complimentary care or respite care, should indicate there would be a better outcome for him than if he had remained at home.

Jan Grant "