A Rest Home/Hospital

Rest Home Manager, Ms C

Clinical Nurse Leader, Ms D

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC16671)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A (dec)	Consumer
Mrs B	Complainant/Mr A's daughter
Ms C	Provider/Manager
Ms D	Provider/Clinical Nurse Leader
Dr E	General Practitioner
Ms F	Registered Nurse
Rest Home/Hospital	Provider
Hospital	A Public Hospital
Rest Home	Rest Home 2
Agency	Needs assessment and service co-ordination agency

Complaint

On 7 November 2006, the Commissioner received a complaint from Mrs B about the services provided to her father, Mr A, by a rest home/hospital. The following issues were identified for investigation:

- *The appropriateness of care the rest home/hospital Manager Ms C provided to Mr A between 19 and 29 June 2006.*

- *The appropriateness of care the rest home/hospital Clinical Nurse Leader Ms D provided to Mr A between 19 and 29 June 2006.*

- *The appropriateness of care the rest home/hospital provided to Mr A between 19 and 29 June 2006.*

An investigation was commenced on 28 February 2007.

Information reviewed:

Information was received from:

- Mrs B
- The rest home/hospital
- Ms C
- Ms D
- Dr E
- A Medical Centre

- The owner of the rest home/hospital
- The District Health Board

Independent expert advice was obtained from Ms Jenny Baker, a nursing and rest home management expert in the field of aged care. Advice was also obtained from the Commissioner's clinical advisor, Dr Stuart Tiller, a general practitioner with vocational registration.

Information gathered during investigation

Background
On 19 April 2005, Mr A (then aged 89) was assessed for home help assistance by the needs assessment and service co-ordination agency contracted to a District Health Board to provide community-based assessments and services to the elderly (the Agency). Although Mr A required some assistance with his daily activities, he was assessed as able to continue to live in his own home. It was noted that Mr A was experiencing problems that included: weight loss, unreliable short-term memory, poor balance, falls, and blackouts. The Agency recommended that he receive home help and a referral to a geriatrician for further review.

In June 2006, members of Mr A's family, and his GP, Dr E, considered that he was no longer able to manage living alone. Dr E said that Mr A's memory was deteriorating, and observed that Mr A hid this by joking about it, because he was determined to remain in his own home. Dr E was also concerned about Mr A's physical deterioration. Dr E said Mr A had difficulty in bearing weight on his right leg following a fall, and this injury was causing pain. In Dr E's view, Mr A required rest home care.

Mr A's daughter-in-law worked for a rest home/hospital, and asked that Mr A be admitted into their care urgently.

On 19 June 2006, Mr A was admitted.

Rest Home/Hospital
The facility (the rest home/hospital) has a rest home and a hospital facility. In June 2006, there were 31 hospital beds and nine rest home beds. A registered nurse was available on site at all times.

The manager, Ms C, was responsible for the overall business management. Ms C was on leave when Mr A was admitted. She returned to duty on 26 June.

Ms C advised that their policy is to complete a full assessment of a resident's condition within 24 hours of admission. This includes a description of medical conditions, mobility, continence, sleeping patterns, personal hygiene and care needs, dietary requirements, and social and spiritual needs. This information is then assessed by a

registered nurse and any potential risks are identified. Assessment tools are used to document, monitor and evaluate the risk factors. Ms C stated that the risks to residents are then identified on the front of the "Health and Care Needs Assessment" form and also transferred to an interim initial care plan. A more detailed lifestyle plan is developed during the first three weeks of residency.

The Protocol for the Recording and Monitoring of Falls states that "each resident will be assessed within the first 24 hours of admission as to his or her risk of falling". A plan to minimise the risk of falling is expected to be incorporated into the Lifestyle Plan.

The clinical nurse leader, Ms D, a registered nurse, was responsible for the assessment, admission, and the day-to-day co-ordination of residents' clinical care. Her job description included the following responsibilities:

- A Short-Term Lifestyle Plan (the Initial Care and Support Plan document) is developed within 24 hours of admission (this includes the documentation of the required assessment tools).
- The resident's abilities and disabilities are documented in the Lifestyle Plan.
- The Lifestyle Plan is amended as a resident's needs change, and that reassessments and evaluations of such changes are accurately documented in the resident's records.
- Each resident is assigned a key worker to oversee their care.
- The input of other health professionals into residents care is co-ordinated (including referrals — and there is a multi disciplinary input into the resident's lifestyle plan).
- When a resident requires increased residential care, this is identified and the appropriate actions initiated.

Ms D also had a responsibility to co-ordinate "Incident Reports".[1] This included the assessment and investigation of incidents, the identification of the appropriate action required, and documenting on the incident report any actions taken. Ms D reported directly to Ms C. Ms D said that as well as being clinical nurse leader, she had overall management responsibility when Ms C was on leave in June 2006. This meant she was working long hours.

Admission to the rest home/hospital on 19 June 2006
Mr A was admitted for respite care and allocated a hospital bed, as a rest home bed was not available. It was noted that the family members present at this time said that

[1] The rest home/hospital states that in the case of a resident falling, an incident report must be filled in for each fall, and the incident reported to the person in charge on that shift and the nurse manager. The nurse manager reviews incidents on a monthly basis and the data from these reviews is then made available to the general manager.

Mr A's condition had deteriorated over the two weeks prior to his admission. An immediate referral was made to the Agency for Mr A to be assessed for subsidised, supported care.

Ms D oversaw Mr A's admission. She said that admission usually followed an Agency referral, but could occur from a request from a family (as it did in this case). Ms D said that the urgency of this admission, the fact that conflicting information was provided by different family members concerning Mr A's health history, and the lack of current Agency assessment information, led her to conduct her own assessment of Mr A.

Ms D began the documentation required to complete Mr A's admission. This included a 12–page General Admission Form (incorporating a consent form) outlining the services provided to residents. An Admission Checklist was partially completed, with no information recorded under the section for "medical records obtained or requested", or identifying who his key worker would be. Ms D said that following Mr A's admission a Support Needs Assessment Form was obtained from Dr E, which provided a more complete picture of Mr A's health.[2]

A three–page Initial Care and Support Plan was also commenced by Ms D and registered nurse Ms F. This document uses a tick box format to gather general information on hygiene, dentures, diet, general condition, sleep, pressure areas, wounds, social behaviour, disabilities, mobility, elimination, psychological assessment, and medications. Mr A's mobility was ticked as "up unaided" and his "general condition" was written as "confused ?". On the second page of this plan, Ms F recorded: "Required showering Odour. Not taking his medication at home. Not taking food at home." It is unclear how Ms F obtained this information. Ms F detailed the actions to be taken to help Mr A to manage these matters. The date of this entry is not clear. The section completed by Ms F is dated 26 June 2006, but signed by her as 19 June 2006. The document does not identify any significant concerns regarding Mr A's health.

The Health and Care Needs Assessment, also in tick box format, recorded an admission date of 19 June, although written entries to this document are dated 23 and 26 June. Under the section "Risk Alert", boxes were ticked to indicate that Mr A was at risk of falling, smoked, and had a hearing problem. It was also recorded that Mr A ate well. Again, there is no specific or detailed information concerning Mr A's health. An undated, one-page Resident Profile notes that Mr A had a history of falls at home and was at risk of falling.

[2] This was the Agency assessment of 19 April 2005, and the information it provided was more than a year old. Mrs B believes that the information gathered in this assessment was incorrect.

Mr A signed his consent to being admitted, and indicated that he wanted Dr E to provide his ongoing medical care.[3]

Ms D's initial assessment of Mr A is also documented in the Care Progress Notes. These note that he was significantly deaf, had a history of falls, and that he did not manage his medication requirements or eat appropriately. He appeared not to wash or change his clothes, and was possibly incontinent. Mr A's vital recordings were taken by a registered nurse that afternoon, and recorded in his Care Progress Notes. It was noted that he had "quite a lot of bruising on his arms" and his skin was dry and cold.

On the evening following his admission, Mr A was visited by Dr E, who advised Ms D that he was not attending as Mr A's doctor, and would not be providing Mr A's ongoing GP care. Dr E explained that he came to see Mr A as he was concerned for Mr A's psychological well-being, and wanted to ensure that he had consented to stay. However, Dr E did complete and sign some medication dosage information on the Regular Medication Sheet.

The Care Progress Notes record that on his first day at the facility Mr A was agitated and disorientated, and made a number of attempts to leave. The registered nurse's afternoon notes state:

> "Quite confused this afternoon. Tried to get out of the window. Opening and closing drawers. Thought [there] was a door [where] the wall is in the shower."

Mr A was unsteady on his feet and complained of pain in his right knee, for which he was given Panadol that evening.

During the day on 20 June, Mr A was recorded as being settled, and eating and drinking well. However, during the night shift he was found looking for a toilet and was noted to be restless, disorientated, and confused. After being returned to his bed, Mr A was incontinent. His bed linen and pyjamas were changed, and he was provided with an incontinence pad.

On 21 June, Mr A's Care Progress Notes record that he appeared settled. Mr A was assessed by the Agency and it was determined that he required "full assistance with all daily activities at rest home level SNL (Support Needs Level) 4" This indicated that Mr A required a high level of rest home care. (SNL 5 is an indication that private hospital level care is appropriate.) Mr A's family members were present during the assessment. However, nursing staff were not included in this process or asked to

[3] The Admission Form (contract) advises that private paying residents can retain their GP, if their doctor is willing to continue providing their care. The contract states that they contract with a doctor from a medical clinic, who "visits at least weekly". On 22 June, a doctor held a morning clinic and reviewed 10 residents. Mr A was not on the list seen by a doctor.

provide information on Mr A. During this assessment Mr A accepted that he required permanent rest home care. Later in the day, Dr E visited Mr A. Dr E described this visit as unofficial, but he did enter and sign off on information in the medication sheet.

The following day, during the afternoon, Mr A was disorientated and confused, and needed to be taken back to his room. On the morning of 23 June, Mr A was confused and wandering. Ms D recorded that Mr A was to be "medically admitted" the following week. That afternoon and during the night, Mr A was incontinent. He was returned to his room more than six times, and staff were advised to monitor his whereabouts.

In the early hours of 24 June, the registered nurse on duty found that Mr A had been incontinent and attended to him. She noted that Mr A was out of bed a further eight to nine times throughout the rest of her shift. She completed an incident report stating that Mr A required frequent monitoring, as he was wandering during the night. She advised the use of a sensor mat to alert staff as to when Mr A left his bed.[4]

In the early hours of 25 June, Mr A was incontinent. He was attended to, placed on an incontinence pad, and settled back into bed. At approximately 6.45am the registered nurse on duty found Mr A out of his room. The Care Progress Notes describe that she:

> "found him walking … told that he had a fall. Walking [with] some difficulty; verbalised painful knee. Skin tear on back of head. Rt elbow bleeding ++. Bruise and skin broken down approx[imately] the size of 50 cents on head … doesn't know how he fell down … Reported pain on both knees (more on right knee) and pain on lower chest along the rib margin. No swelling noted, no bleeding."

The registered nurse treated Mr A's wounds, assessed his mobility and levels of pain, and gave him Panadol. She ensured that he could reach the call bell and advised him to stay in bed. She noted that the family should be informed of his fall and condition, started a Wound Monitoring Form, and completed an incident report.[5] The family said that they were not informed of this fall.

By late morning Mr A's right hip joint and neck of femur were visible through his skin. It was suspected that Mr A had dislocated or fractured his right hip, and he was transferred to a public hospital (Hospital). An X-ray was taken but the hospital found no evidence of a fracture. Mr A was prescribed codeine for pain relief and returned to the hospital that evening. The hospital noted "consider reassessing level of care but will

[4] In an additional note to this report dated 28 June 2006, Ms D wrote "? Disorientated due to the move from home to hospital".

[5] On 26 June 2006, Ms D placed an additional comment on this incident report (under "Any other action taken"): "Hx [history] of falls at home sent to A&E? #NOF [neck of femur] as [Mr A] was in pain not weight bearing."

probably be OK if continues to mobilise with aid of frame". On his return from hospital, Mr A wanted to return home, and was "weak and wobbly" and restless. He was placed in a room near the nursing station so that he could be more closely monitored. At 10pm Mr A fell again. The registered nurse on duty recorded that he could not be left alone as he remained unsettled and wanted to leave.

In the early hours of 26 June, Mr A was given further codeine, but this did not settle his pain. He also wanted to pass urine but was unable to do so. At 3.15am, following consultation with Hospital Accident & Emergency staff, Mr A was re-admitted to hospital and catheterised.

Mr A returned to the rest home/hospital the same morning. He required close supervision to prevent him from removing his catheter. His mobility was compromised, and he appeared to be in a lot of pain. A blood clot was visible in his urine catheter bag. A Hydration and Bowel Chart was commenced. When not in bed, Mr A was placed in a wheelchair, but he continued to try to walk unaided. A registered nurse recorded in an incident report that at 10am:

> "[Mr A] was found on the floor by his wardrobe. It is likely he walked there and fell over as he is … confused, and at risk of falls. He has had several falls in recent history. 3 in the last 24 hours."

Ms D subsequently noted on this incident form that the cause of the falls was unknown. The family said that they were also not informed about these falls.

During the evening of 26 June, Dr E called in to see Mr A. Mr A complained of pains in his right leg. Dr E examined Mr A's legs but was unable to identify a cause. Dr E indicated that it had been another unofficial visit and he declined to write in the medical notes. However, he said that he would discuss the matter with Ms D the following morning. Mr A was given Panadol for pain relief.

Mr A did not settle that night, and later he was found kneeling on the floor. To alleviate the risk of further falls, staff placed him on a mattress on the floor, but he continued to be unsettled.

On 27 June, Mr A was still experiencing pain in his legs. He slept through the morning and was given codeine in the afternoon. In the evening, Mr A was again reviewed by Dr E as "[Mr A] was noted to be not well". Mr A's family were concerned at the number of falls he had sustained since his admission to the rest home. Dr E noted that Mr A had been admitted twice to Hospital, and that on one of the admissions an X-ray was taken, which did not show any fractures. Dr E also noted that Mr A was unable to walk, and his right knee was tender along the joint. He recorded that Mr A had developed a chill, and was wheezing and coughing up mucus. Dr E prescribed further codeine, and ordered an X-ray, blood tests and a urine culture to identify whether Mr

A had developed a chest infection or a urinary tract infection. Dr E recommended that Mr A be given fluids, and have his vital signs and bowel function monitored.

Following this, Mr A had a more comfortable night. On 28 June, he was taken for an X-ray by his family in their car. Mrs B said that the rest home/hospital was unable to provide transport, and that Ms D and other staff had watched them put Mr A into the car. Mrs B said:

> "Our father cried in pain as we lifted him in and out of the car. Dad could not stand or even sit during the X-ray."

On Mr A's return, he remained settled for the rest of the day and overnight. However, on the morning of 29 June, a registered nurse recorded that Mr A had fallen at about 9.30am and sustained skin tears to his head, nose and left hand. An incident report was not provided for this event.

Mrs B said that she telephoned the rest home/hospital that morning and was told that Mr A had passed a comfortable night and had eaten breakfast. However, when the family arrived after 10am, Mr A had bruising to his face, and they understood that his nose was broken. They believed he had been assaulted. (The family later provided photographs taken that morning. These included one of blood–staining to the carpet of Mr A's room, and one of a bloodied towel on a chair in the shower in the ensuite.) Mrs B said that she was informed by nursing staff that Mr A did not require medical attention, but that neither Ms D nor Ms C were able to adequately explain the cause of her father's injuries.

The family called Dr E, who was on leave; however, when he was contacted by his receptionist, he agreed to attend immediately and review Mr A. Dr E assessed Mr A as being conscious and co-operative, but noted that his memory was poor. Dr E documented:

> "Called in by relatives to see [Mr A] because he appears to have had a few more falls last night or this morning. It appears that he does not remember that he has difficulty putting weight on leg and then while trying to get out of bed — has falls because he cannot bear weight … The family has also noted that he is sleeping a lot as well. They are very concerned as to why he is not walking and how best to make him safe and prevent these falls."

Dr E was concerned at the deterioration of Mr A's physical and mental health, and referred him to Hospital. He was admitted later that afternoon of 29 June.

Dr E stated:

> "The family notified me of their dissatisfaction with the Rest Home on my visits to see [Mr A]. They stated that [Mr A] had had falls on many nights only to be found by the relatives the next morning covered in blood and often on the floor. I had

> observed obvious signs of injury to [Mr A's] face and head during my visits there. This I presume [was] due to the falls."

Mr A did not return to the rest home. He remained an inpatient at Hospital until 7 August 2006, when he was transferred to another rest home (Rest Home 2). He died a few weeks later.

Complaint

In October 2006, Mrs B raised her concerns with the rest home/hospital by telephone. Ms C said that she and Mrs B had a long conversation regarding the care Mr A received.

Mrs B believes that her father did not receive adequate care while at the rest home/hospital, and that his medical problems and the falls he sustained were not appropriately treated or managed. She feels that the rest home/hospital should have had Mr A transferred to hospital for specialist care. She is particularly distressed that the family had to transport Mr A in their car to his X-ray appointment on 28 June when it was evident that he was in pain whenever he was lifted.

The rest home/hospital's response

On 3 November 2006, Ms C wrote to Mrs B. Ms C said that she had read through the Care Progress Notes, and Incident Reports, and interviewed staff still working at the facility who had provided Mr A's care. Ms D had, by this date, resigned and left. Ms C wrote that she believed that Mr A had received good nursing care and that staff had been sufficiently aware of Mr A's risk of falling and had taken adequate steps to manage this.

Ms C has subsequently resigned. In her response to this Office, she acknowledged that it was unclear why Mr A had continued to fall during his 10 days at the rest home/hospital. Ms C accepted that the rest home/hospital did not do a falls risk assessment for Mr A. However, it remained her view that the clinical staff were sufficiently aware of Mr A's risk of falling and monitored this appropriately. Ms C also noted that when the Agency assessed Mr A on 21 June, the assessment did not raise any concerns about Mr A's clinical care or requirements.

Ms C stated:

> "While we failed to communicate clearly to the family and to document clearly the communications and assessments that took place as I would have liked and expected, our actions were by no means intended to disregard, disrespect or endanger [Mr A] or his family."

Ms C believes that she should have formalised Mrs B's contact with the rest home/hospital in October 2006 as a complaint, and met with the family to discuss their concerns. She has apologised to the family that staff did not adequately communicate with them concerning Mr A's condition or his ongoing care.

Ms D said that, on admission, Mr A was able to walk without difficulty, was aware of his surroundings, and took an active part in the admission process. She believes that the initial assessment of Mr A was influenced by his immediate family not being in agreement with each other as to the most appropriate treatment required by him while he was there. This meant that staff were trying to address communication issues with the family as well as managing Mr A's care. Ms D accepts that Mr A's overall health was poor and that he continued to deteriorate over the 10 days he was there but, in her view, the family did not raise clear concerns with her or other nursing staff about this during Mr A's residence.

Ms D said that Mr A received constant nursing care while at the rest home/hospital. In her view this was of an appropriate standard, with falls and other health concerns adequately documented, managed, and monitored. This included the two admissions to hospital for treatment. Ms D said that she was grateful that Dr E was able to provide some medical support for Mr A, given that the rest home/hospital had difficulty accessing GP services at this time.

Ms D accepts that she should have paid more attention to documenting Mr A's patient records, staff interactions with family members, and the informal visits made to Mr A by Dr E.

GP care and availability

Ms D, Ms C and Dr E state that providing general practice services for Mr A during his stay was an ongoing problem. Ms C advised that, for private residents requiring respite care, it was common practice for their GP to continue to provide their medical care. Dr E expected the rest home/hospital to provide Mr A with medical services, and he advised them that he was unavailable to continue as Mr A's GP once Mr A was admitted into residential care. This concerned Mr A's family because Dr E had been Mr A's doctor for a considerable time. Ms D said that she had made attempts to have the rest home/hospital's contracted GP services review Mr A, but on all occasions there was no GP available to attend. The situation was complicated by Mr A's status (as a private patient and then a subsidised patient) and by the other doctors' view that Mr A was Dr E's patient. Because of this, Ms D said that she contacted Dr E when she believed Mr A required immediate medical review or assistance.

The rest home/hospital, along with other aged care services in the region, had difficulty accessing GP services because of a shortage of GPs in the region. Although this matter was raised with the District Health Board, the Primary Health Organisation, and the contracted GP organisation (the Medical Centre), it remained a problem. Ms C stated:

> "Over the past year I have highlighted on many occasions with [the] DHB that we are having issues accessing GP cover when we require it. … The issue has been attributed to GP shortages and perceived poor monetary return by the GPs and or their Practices. While we have tried to problem solve this issue with the DHB, the provision of services has reduced and costs increased. We have no after hours cover in [the area] and therefore often have to resort to sending Residents

> unnecessarily to [the DHB] via ambulance for medical input which is traumatic for elderly Residents and their families, not to mention our staff who feel unsupported and who are trying their best to provide professional and caring services. Currently, the provision of services with the [Medical Centre] for [the rest home/hospital] (which was under review when I left) included a weekly clinic and emergency visits as required if the GP can make it. This situation creates uncertainty for us and while we maintain our contractual requirements, it is not ideal."

The Medical Centre confirmed that it did not provide after-hours care and provided only two to three hours a week, on-site medical care to the rest home/hospital. They advised me that it has no record of ever being contacted by the rest home/hospital and asked to review Mr A.

Dr E attended Mr A at least four times during his stay at the rest home/hospital, but consistently stated his reluctance to provide Mr A's ongoing GP care. Dr E recalls:

> "I visited [Mr A] while he was in [the rest home/hospital]. Apart from one visit, all other visits [were] on a social basis as he had been transferred to the in-house doctor. My visits to [Mr A] at the Rest Home were more to see how he was coping in the new environment that he had been quite reluctant to go [to]."

Ms C stated:

> "I believe these issues may have impacted the care we were able to access for [Mr A] despite our best efforts to acquire a GP consultation."

Responses to my provisional opinion

Ms D

Ms D said that she has reflected on these events and my findings and made changes to the way she works. She understands that as a clinical nurse leader she has an additional responsibility to her patients. She said that she is now more conscious of her obligation to use assessment tools effectively, and to take appropriate action to manage incidents as soon as they are brought to her attention. Ms D has agreed to regularly reflect on, and review, her nursing practices. She is now being supervised and supported by a nurse mentor.

In summary, Ms D stated:

> "I believe that through this process of reflection and evaluation [of] my professional practice [this] has led to me becoming a better nurse, and will result in improved care for my clients in the future."

Ms D provided a letter of apology to Mr A's family.

The rest home/hospital
The rest home/hospital has appointed a clinical services manager to assist staff with professional development through in-service training and educational opportunities.

The Initial Care and Support Plan has been altered so that it is more comprehensive. It includes a requirement for sign-off from families to confirm that they have been consulted. Indwelling catheter, falls assessment and wound and pain assessment tools are also now included as part of the plan. The rest home/hospital has indicated that it will review other documents and the tools it uses to support the care of its residents. In particular, it will address the manner in which it manages communication with its residents and their families, the transport of residents to outpatients services, incident reporting and documentation.

The rest home/hospital has contracted an after-hours doctors service from the Medical Centre and confirms that formal medical admissions of subsidised residents are now carried out within two working days of their admission.

Mr A's family
Mr A's family, in a joint response, said:

> "We as a family have endured a tremendous amount of stress in the very short time Dad was at [the rest home/hospital] … [it] is still affecting us and we still do not have any understanding of how someone … can … be treated with such a lack of dignity and respect."

Independent advice to Commissioner

The independent expert advice from Ms Jenny Baker, a nursing and management expert in the field of aged care, is attached as **Appendices 1 and 2**. The advice from the Commissioner's clinical advisor, Dr Stuart Tiller, a general practitioner, is attached as **Appendix 3**.

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

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.

Relevant standards

Nursing Council of New Zealand Competencies for Registered Nurses Scope of Practice. Approved by the Council June 2005.

Competency 2.2: Undertakes a comprehensive and accurate nursing assessment of clients in a variety of settings.

Indicators: Undertakes assessment in an organised and systematic way. Uses suitable assessment tools and methods to assist in the collection of data.

Competency 2.3: Ensures documentation is accurate and maintains confidentiality of information.

Indicator: Maintains clear, concise, timely, accurate and current client records within a legal and ethical framework.

Opinion

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

Opinion: Breach — Ms D

Introduction
Mr A was entitled to have services provided with reasonable care and skill, and that complied with the relevant professional standards. The care he received was, to quote my expert advisor Ms Baker, "mixed". While some of the care was good, and appropriate, in several areas it could have been significantly better.

As clinical nurse leader, Ms D was responsible for the co-ordination of Mr A's care. It was her responsibility to ensure that he was appropriately assessed, information was correctly documented and, as his needs changed, these were identified and documented, and appropriate action taken. These are all areas where inadequacies were identified.

Assessment and documentation
Mr A's admission to the rest home/hospital was urgent, and Ms D has said that it occurred amidst conflicting stories about his needs. Regardless of the circumstances surrounding Mr A's admission, the assessment and documentation initiated at that time needed to be accurate, and to contain sufficient information to ensure that he would receive the appropriate care. Ms D was responsible for ensuring that this was done.

Mr A was admitted because his doctor and some of his family were concerned that he was no longer able to live safely in his own home. In particular, Mr A had a history of blackouts, he was not eating or taking his medications, and he may have been incontinent. Mr A's family believed his condition had deteriorated during the two weeks prior to his admission. When Mr A's vital recordings were taken on the day he was admitted, bruises on his arms were noted by the nurse.

It is evident that Ms D was provided with sufficient information to ensure that both the Health and Care Needs Assessment and the Initial Care and Support Plan contained enough information to alert nursing staff to the areas where Mr A required closer monitoring. However, as noted by Ms Baker, what was recorded in these documents was sparse, conflicting, and incomplete, and did not sufficiently reflect Mr A's medical history or the problems he was likely to present for those providing nursing care.

Like Ms Baker, I acknowledge that the tick box format of these forms made it difficult to document detailed information. Nonetheless, the function of the tick boxes was to act as prompts, to alert nursing staff to potential problems that may occur in providing a resident's care. It was Ms D's responsibility to ensure that the Initial Care and Support Plan was sufficiently detailed to clearly identify to nursing staff Mr A's known medical and physical problems at the time of admission, and to initiate the assessment tools required to manage these. This did not happen. As Ms Baker noted, a continence assessment tool was clearly needed and was not begun.

Furthermore, Ms D also failed to follow the Protocol for the Recording and Monitoring of Falls, requiring Mr A's noted "risk of falling" to be assessed within the

first 24 hours following his admission. This is particularly concerning given that falls were identified as an issue from the outset.

Management of Mr A's falls
On Mr A's first day, he was confused, attempted to leave by a window, was unsteady on his feet, and was found wandering. Five days later, on 25 June, Mr A fell and an incident report was completed. On 26 June, Ms D wrote that the cause of Mr A's falls was unknown. Mr A continued to fall up until his admission to hospital on 29 June. Ms Baker noted that the Falls Policy (dated December 2002) states:

> "A Nursing Assessment Post Fall Form to be completed following falls. The Protocol for the Recording and Monitoring of Falls states: 'In the event of the same Resident suffering repeated falls or accidents, they will be referred to and assessed by the doctor, physiotherapist and the primary nurse and the plan of care changed accordingly'."

Incident reports were filled in but there was little follow up. In an incident report of 24 June, reporting a fall, the registered nurse suggested the use of a sensor mat to monitor Mr A when he left his bed. However, there is no evidence that Ms D considered this option or took the suggestion further. Although an attempt was made on 26 June to nurse Mr A on a mattress on the floor, this was for a short time and it did not prevent him from getting up and continuing to walk. There is no evidence to indicate that any nursing assessment took place in relation to Mr A's recognised risk of falls, or that any other health professional was specifically approached to investigate why Mr A continued to fall. In my view, there was no point in completing incident reports and having them signed off by Ms D, if there was no follow up to determine the cause of the incident and take remedial and preventative action. This situation needed more proactive action than simply changing Mr A's sleeping arrangements.

Ongoing care planning
As well as the falls, other aspects of Mr A's health deteriorated during his brief residency at the rest home/hospital, causing both him and his family additional distress. Mr A's incontinence increased to the extent that he required catheterisation. Mr A complained of pain in his knees and lower chest and, although he was prescribed codeine phosphate and Panadol for pain relief, his pain persisted until he was admitted to hospital on 29 June.

Ms Baker commented that neither Mr A's ongoing pain nor his incontinence problems were adequately managed. Although there is sufficient documented information to suggest that nursing staff were aware of and concerned about these matters, there is insufficient evidence of actions being taken to manage the situation. A bowel chart was commenced on 26 June but there is no evidence to suggest that nursing staff considered monitoring the impact of the codeine phosphate on Mr A's bowel function. Mr A was admitted twice to hospital on 26 June, but again there is no evidence to suggest that the hospital was asked to undertake a more intensive review of him at this time.

Ms D's job description shows that it was her responsibility to ensure that Mr A's needs were reassessed. There were clearly signs that he may have needed greater care. Yet, as Ms Baker noted: "There is no documented evidence that the Initial Care and Support Plan was reviewed during the 10 days even though it was apparent that [Mr A's] needs were quite different from those identified on admission."

Ms Baker commented that the nursing staff should have advocated for Mr A to ensure he was assessed for a higher level of care.

Transfer to X-ray appointment
On 28 June, Mr A was transported in his daughter's car to a radiology service for an X-ray. At this stage, Mr A was in a wheelchair and experiencing significant pain. Ms Baker said:

> "In view of the fact that [Mr A] was agitated, confused, trying to stand up and falling, had a catheter insitu, was being X-rayed for a possible fracture of the knee and had difficulty weight bearing, I believe [the rest home/hospital] should have sent [Mr A] in an ambulance for the X-ray."

Mrs B said that Ms D was present while she was placing her father into the car. In my view, Ms D had a responsibility to ensure that Mr A was safely transported to this appointment, and did not meet this obligation. This caused unnecessary stress to Mr A and his family.

Accessing medical care
Ms D found it difficult to access GP services to review Mr A. This was because of a shortage of GPs in the area. She was grateful that Dr E was able to oversee some of Mr A's care. Ms Baker also noted the lack of formal medical review, the difficulties this posed, and the impact that it had on the provision of Mr A's care. Ms Baker was of a view that a GP needed to be involved.

Dr Tiller advised me that:

> "[Dr E] did not make notes at the time of his first visit on 26/6/06 as he did not perceive that visit to be a formal medical consultation. He wished to discuss his involvement in care for [Mr A] with the clinical nurse manager the next day. Thereafter he did keep good clinical records on 27/6/06 and 29/6/06 and undertook appropriate clinical assessments and laboratory investigations. By the time of this third visit on 29/6/06 he recognised the need for hospitalisation."

Dr Tiller advised that Dr E provided appropriate care in circumstances where he was not visiting in an official capacity, and he took timely action when he did assume "clinical responsibility". Dr Tiller believes that the rest home/hospital should not have admitted Mr A if they could not provide adequate medical services from a contracted GP. He advised that it was apparent early on that Mr A required urgent medical

assessment, and he believed it was the responsibility of the clinical nurse leader to follow this up.

Dr E's attendance at the rest home/hospital to see Mr A in an unofficial capacity, and his actions, may have given Ms D and registered nursing staff the impression that he was providing Mr A with ongoing medical care. While it is commendable that Dr E did provide care to Mr A when there was no other medical service readily available, and that he was so concerned for his former patient, it appears that this arrangement may have confused matters for the nursing staff.

I also note Ms D's comment that when she tried and was unable to get one of the contracted doctors to attend Mr A, this was complicated by their view that he was Dr E's patient. Nonetheless, while I accept that the problems obtaining contracted medical care made it difficult for the nursing staff, Ms D's job description clearly indicates that when a resident required increased care it was her responsibility to ensure that this was identified, and the appropriate actions initiated. Dr E had indicated at the outset, and subsequently, that he would not provide Mr A's care at the rest home/hospital. Ms D was responsible for co-ordinating the input of other health professionals and referring residents to other professionals or agencies when necessary. If she was unable to do so, she had a responsibility to advocate on behalf of the residents and take appropriate action.

In my view, Ms D had sufficient information to indicate that Mr A was not receiving adequate care, but there is no evidence of either a continence care plan, or a pain assessment being instigated when it was clear that he was experiencing ongoing problems in these areas. There is no evidence that Ms D referred Mr A to a physiotherapist in line with the protocol for falls; no documented evidence that she discussed with a GP the difficulties they were having managing Mr A's falls, agitation, and wandering; or that she asked for Mr A to be referred for a geriatric assessment. As Ms Baker advised:

> "In conclusion it is clear that [Ms D] did not completely fulfill her role for [Mr A's] case."

Summary
Ms D did not take sufficient action to manage Mr A's sudden deterioration in health. She did not ensure that the appropriate documentation was completed, amended or updated in line with the requirements of her job or the Nursing Council Scope of Practice. Despite Mr A's ongoing falls, incontinence, and pain, Ms D did not initiate the relevant assessment tools or ensure that he was referred for assessment by a physiotherapist or doctor. Accordingly, I find that Ms D did not exercise reasonable care that complied with professional standards, and breached Rights 4(1) and 4(2) of the Code.

Opinion: No breach — Ms C

As manager of the rest home/hospital, Ms C's main responsibility was the business management, and her clinical role was limited. The clinical nurse leader, Ms D, reported to her, and she reviewed data collated from incident reports, monthly.

Ms C was on leave when Mr A was admitted on 19 June, and she returned to work on 26 June. By this stage, Mr A had returned to the rest home/hospital following two brief hospital admissions. In the three days leading to 29 June, Mr A was reviewed twice by Dr E, underwent an X-ray and other tests, and was again, following a fall, hospitalised.

Ms C learned of the family's concerns when Mrs B initially contacted the rest home/hospital in October 2006. She has acknowledged that the appropriate documentation was not completed to an acceptable standard. However, following her review of this matter, Ms C believed that the registered nursing staff were sufficiently aware of Mr A's risk of falling, and that he was monitored appropriately during his 10 days of residency.

Ms C also acknowledged that the rest home/hospital did not clearly communicate with Mr A's family concerning his progress or the deterioration of his physical and mental health. Ms Baker commented that:

> "[The] Rest Home Manager appeared to make a genuine effort to investigate and discuss the concerns with the family; however, it could have been handled differently with personal interface between the parties."

I note that Ms C has apologised to Mr A's family about the manner in which her staff communicated with them. I am satisfied with the actions taken by Ms C to address the concerns raised by Mr A's family.

Ms C did not have a direct responsibility for the clinical care of Mr A, and could not have foreseen Ms D's failure to document and adequately co-ordinate and manage Mr A's ongoing care. Accordingly, in my opinion Ms C is not in breach of the Code.

Opinion: No Breach — The rest home/hospital

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee's act or omission that breached the Code.

The rest home/hospital provided me with a copy of the job description for the clinical nurse leader, which clearly outlined her responsibilities. It is evident from this

document and the policies provided that there were sufficient structures in place to provide for the appropriate assessment and admission of residents, and that this was Ms D's responsibility. In my view, there is no evidence that the rest home/hospital was responsible for Ms D's breach of the Code.

My expert, Ms Baker, has highlighted ways in which the falls risk, pain management, transportation of Mr A to hospital, and the interaction with, and response to, the family, could have been handled better. However, she has advised that overall Mr A received appropriate care during his stay there, with, in particular, a good level of registered nurse input, and good documentation within the progress notes from both nurses and carers. Accordingly, I do not find the rest home/hospital in breach of the Code.

Other comment

The rest home/hospital

Ms C and Ms D have said that there were difficulties obtaining general practice care for residents during Mr A's stay there. This was largely due to a shortage of GPs in the area.

Both Ms Baker and Dr Tiller have commented on the impact this had on Mr A's care. Dr Tiller advised that the rest home/hospital should not have admitted Mr A if the staff could not guarantee adequate medical services from the contracted GP practice. He advised:

> "The apparent difficulty in sourcing care from the 'Doctors' [the Medical Centre] other than at the time of a routine weekly visit also raises concern as to whether [the rest home/hospital]could provide adequate medical care to other residents of their institution."

Ms Baker questioned whether the rest home/hospital breached its funding contract by failing to have Mr A formally medically reviewed within two days of his admission and once he became a subsidised resident. She advised:

> "The Aged Related Residential Care Contract states: 'D16.5 4 Primary Medical Treatment i) You must ensure that: 1. each Subsidised Resident is examined by a General Practitioner within 2 Working Days of admission, except where the Subsidised Resident has been examined by a Medical Practitioner not more than two Working Days prior to admission, and you have a summary of the Medical Practitioner's examination notes'."

Ms C stated that the rest home/hospital did maintain its "contractual requirements", because a GP was available to attend once a week for a clinic and "for emergency visits as required if the GP can make it". However, this does not appear to be the case

concerning Mr A. Although Dr E was visiting Mr A, these were primarily social visits, and he said more than once that he was not providing Mr A's ongoing care. Mr A was not seen by a contracted GP during the 10 days at the rest home/hospital, and there is no evidence to suggest that the Medical Centre was contacted by the rest home/hospital and asked to attend and review Mr A, despite an evident and rapid deterioration in his health over this time.

Ms C has explained the steps that were taken by the rest home/hospital, along with other local rest homes, to try to remedy the difficulties in accessing GPs. They had repeatedly raised the problem with the District Health Board.

I accept that the rest home/hospital was trying to address the issue. However, given that this was a recognised problem and little progress was being made, it is my view that they should have reviewed whether it could continue to accept residents who were as unwell as Mr A when there was such limited access to GP services. The staff needed clear direction on this. At the very least, this situation needed to be made clear to prospective residents and their families. This is particularly concerning given the high number of hospital beds.

Dr E's involvement
Dr E visited Mr A out of concern for the well-being of a former patient. He wanted to ensure that Mr A had consented to his admission. Dr E did not wish to continue caring for Mr A at the rest home. He indicated that this care should be provided by the contracted service, but he ended up continuing to provide some clinical care to Mr A. This was initially in an unofficial capacity.

As I have commented previously, Dr E had Mr A's best interests at heart. However, the way in which he was involved, and his actions, seem to have muddied the situation and created some confusion around whether Mr A was receiving sufficient medical oversight. I asked Dr E to reflect on this and whether more clarity about his involvement was needed. He has accepted that he could have been clearer with nursing staff about his role. He has indicated that he will be mindful of this in future when other patients of his are admitted to rest homes.

Recommendations

Ms D and the rest home/hospital have reviewed their practice in light of these findings, and appropriate changes have been made.

Ms D has provided Mr A's family with a written apology.

In response to my provisional decision, the rest home/hospital has undertaken to make further changes concerning GP contracts, incident reports, documentation, transport of

residents to outpatients services, and communication with families and residents. I have requested a progress report on these changes by **29 February 2008**.

Follow-up actions

- A copy of this report will be sent to the District Health Board, the Ministry of Health (HealthCERT), and an anonymised copy will be sent to the Royal New Zealand College of General Practitioners. Their attention will be drawn to the difficulties of accessing GP services in the region.
- A copy of this report will be sent to the Nursing Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1

Independent advice to Commissioner

The following expert advice was obtained from Ms Jenny Baker:

> **"Professional Profile**
>
> I registered as a Registered Nurse in 1978. From 1978 to 1981, I worked as a Staff Nurse in Oncology. From 1981 until 1995, I worked as a staff nurse in acute wards, initially in medical wards and then in continuing care (post children) and then across all acute wards at Wairau Hospital. In 1995, I was Clinical Nurse Coordinator in an Assessment, Treatment and Rehabilitation Ward (A, T & R) before taking up the position of Unit Manager, A, T & R Unit, The Princess Margaret Hospital. I then held the position of Nurse Manager of a 99 bed private hospital for Aged Care. This included a Dementia wing, and palliative and young disabled residents. From 2002 to 2004 I worked as a Nurse Consultant providing documentation development and implementation for the Health and Disability Standards Certification and the Ministry of Health Contract. I also provided general consulting advice and training for both staff and managers. This was primarily with Aged Care facilities nationwide. During that time I kept my clinical skills current by working as an Agency Nurse in both the Public and Private sectors. From 2003 to 2004 I was a Lead Auditor for a Designated Auditing Agency against the Health and Disability Standards Certification. From 2004 until 2005, I worked as a National Quality and Training Manager for a company who owned retirement villages with rest homes and hospitals nationwide. I currently work as a Care Manager in a rest home and rest home dementia. I have provided expert advice to the Health and Disability Commissioner in the Aged Care area since 2002.

[At this point Ms Baker notes the facts gathered provided to her by this Office and the questions asked of her. These have been omitted for the sake of brevity. See Appendix 2 for a list of documents reviewed by Ms Baker.]

> 1. I have been asked to provide an opinion about the standard of care that [Mr A] received while at [the rest home/hospital]
>
> **The steps taken by [the rest home/hospital] to manage and care for Mr A from his admission on 19 June 2006 to his transfer to [Hospital] on 29 June 2006.**
>
> [Mr A] was admitted urgently on 19/6/06 for privately funded respite care while waiting for the Agency to reassess him on June 21 2006, when at that stage he became a subsided resident as the family were to apply for a subsidy for permanent rest home care. Respite clients generally do not have their SNL (Support Needs Level) form faxed to the residential facility; they are normally

only sent for permanent residents and in [Mr A's] case, he was initially a private respite resident. In order to obtain information about their diagnoses and medication, the usual practice is for the resident's GP to be contacted and requested to fax through this information. The list of diagnoses gives vital background information to the staff, particularly the admitting Registered Nurse, in order to accurately assess the resident and plan their care by being able to ask appropriate questions. It is essential for the list of medications, doses and times given so that the staff can use this list to administer against until the resident is formally admitted by a Doctor. In [Mr A's] case, it does not appear that [the rest home/hospital] attempted to obtain this necessary information.

Once [Mr A] was reassessed by [the Agency] for permanent subsidised rest home care, [the rest home/hospital] was obliged to comply with the District Health Board's Aged Related Resident Care Contract for subsidised residents. The Aged Related Residential Care Contract states: 'D16.2 c. The assessment utilises information gained from the Subsidised Resident, their nominated representative (where applicable), and information provided by the relevant Needs Assessment and Service Coordination Service and/or previous provider of health and personal care services along with observations and examinations carried out at the Facility'.

On admission the following documents were completed to some extent: Admission Form (Admission Agreement), Initial Care and Support Plan, Regular Medication Sheet and Bowel Chart. The Health and Care Needs Assessment, which I would expect to be part of the admission process, appears to have been partially completed on the 23/6/06.

The Health and Care Needs Assessment is mainly a tick box format with little room for additional comment. The individual assessments within this form are mainly brief assessments and if the scores indicate certain levels then other assessment forms are used i.e. Falls Assessment Form, Assessment for Individual Transferring Requirements, Continence Assessment Tool & Catheter Monitoring Plan, Wound Monitoring Form, Behavioural Management Plan and Pain Management Assessment. There does not appear to be a more in-depth nutrition assessment form if required. The brief assessments do not lead the Registered Nurse into completing more in-depth assessments as the scoring does not seem to lead towards this eg '2 Falls Management No 4 Good. Good. Walks without assistance' is ticked which does not indicate a risk of falls as this assessment requires a score of 3 or less as an indication of falls risk and yet the Nurse has documented 'History risk of falls' under the total score for walking. Of note is that the Falls Management assessment within the Health and Care Needs Assessment Form actually describes walking (mobility), not falls, and does not cover the essential information required to indicate falls risk eg medication, cognitive impairment, history of falls, other factors such as osteoporosis and previous fractures, etc. It is essential to complete a separate in-depth falls risk assessment on all residents admitted as a base line for their care plan; [the rest

home/hospital] does have a Falls Risk Assessment for the Ambulatory Resident Form which was not used for [Mr A].

The inability for the Registered Nurse to document more fully on the form means that the information ticked may not be completely accurate and thus not a true and full assessment on which to base the Initial Care and Support Plan. For example; under '5. Eating & Drinking No 4 Good Eats without assistance and appears well nourished' was ticked and the progress notes on admission states: '19/6/06 1415 not eating meals.' The Initial Acute Support Plan does document the problem of 'not taking food at home'; this is clearly written up because of the information in the progress notes, rather than any information obtained from the Health and Care Needs Assessment Form.

The Health and Care Needs Assessment Form had conflicting information in it e.g. '23/6 Behaviour Cooperative' whereas the progress notes states: '19/6/06 pm cont [Mr A] wanted to climb out his window…Remained agitated; nocte very confused…wanders out of his room to other residents; 20/6/06 Nocte confused and wandering through the hall way; 23/6/06 am very confused and disorientated in the morning, wandering'; '23/6 Sleeping Pattern Sleeps well;' under 1 Activities of Daily Living, Hygiene needs on admission; '23/6 Teeth Denture Bottom' and 'partial plate' are ticked, whereas the progress notes state '19/6/06 1415 top dentures;' '23/6 Continence Management No 3 With regulation Continent with reminding' is ticked, the progress notes state: '19/6/06 1415 ?incontinent of urine family unsure; 20/6/06 04:00 Toilet floor wet with urine and his pyjama and bed linen (top) wet.' A Continence Assessment Tool should be commenced at the first sign of incontinence on 20/6/06 as part of the assessment process for the development of the long term care plan: '20/6/06 04:00 Toilet floor wet with urine and his pyjama and bed linen (top) wet.'

An Initial Care and Support Plan was documented by two staff members. [Ms D], Clinical Nurse Leader, partially completed the Hygiene page on the 19/6/06 and Registered Nurse, [Ms F], completed the Initial Acute Support Plan page on the 19/6/06; this page had three dates on it — 16/6/06, 26/6/06 and 19/6/06 under her signature. I am not sure why both the Clinical Nurse Leader and a Registered Nurse completed parts of the Initial Care and Support Plan as ideally one staff member should have completed the Health and Care Needs Assessment Form and developed the care plan on admission. As [Mr A's] agitation and wandering and falls became apparent, these were not added to the Initial Care and Support Plan, along with goals and interventions, for the carers to follow. The Aged Related Residential Care Contract states: 'D 16.3 Care Planning b. At the time of admission an initial Care Plan is documented in accordance with clauses D16.2 (b) and (c); D16.2 (b) states: Each Subsidised Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 3 weeks, and that Registered Nurse input and agreement is sought and provided in developing and evaluating the initial Care Plan in order to ensure continuity of relevant established support, care and

treatments'. It is clear that [the rest home/hospital] did not fully develop or evaluate their Initial Care and Support Plan or achieve relevant established support, care and treatments during [Mr A's] stay and were not compliant with the contract.

On 21 June [the Agency] reassessed [Mr A] with the family and Doctor. It is usual for Assessors to obtain as much information about their clients, including from health professionals delivering care, in order that their assessment is as complete and accurate as possible. In [Mr A's] case, it appears that the [the Agency] Assessor did not meet with [the] staff to obtain information on [Mr A's] abilities with ADL's, whether they had witnessed any blackouts or had he been falling, and any concerns that [the] staff had about it. I am concerned that this contact did not occur as it was an ideal opportunity for [the] staff to inform [the Agency] about [Mr A's] agitation and wandering which mainly occurred during the evening and night time and would indicate cognitive impairment and sundowning or delirium.

It is clear by June 23 that [Mr A] was doubly incontinent (urine and faeces) and required a continence assessment to be completed. [Mr A] first fell on June 25 and required a falls assessment to be completed. [Mr A] had complained of pain in his R) knee on June 19 '19/6/06 pm cont Complained of pain in groin down to R knee' and again was complaining of pain in his right knee and additionally his left knee and lower chest following his fall on June 25 '25/6/06 6.45hr Verbalized painful knee…Reported pain on both knees with more on Rt) knee and pain on lower chest along the rib margin;' I would have expected a pain assessment to be completed at this point. I note that the Health and Care Needs Assessment Form stated: '26/6/06 Pain Experience No pain — Has no pain related to condition,' yet [Mr A] had clearly expressed pain. A formal pain assessment was not completed and documented, despite both staff and [Mr A] reporting significant pain on several occasions. I did note, however, that on 25/6/06 [Mr A's] pain was partially assessed as the progress notes states: '25/6/06 am Painful ++ 8/10.'

I note that [Mr A] was given Diazepam, Paracetamol and Codeine Phos during his first visit to A&E at [Hospital] 'Treatment and medications administered by ED. Diazepam, Paracetamol and codeine — good relief from diazepam.' 'Diazepam ? continued from visit to A & E on June 25' as it was noted in the progress notes that it was discontinued: '27/6/06 PM. S/B [Dr E] 1800 hrs ... Diazepam discontinued.' There is no record of the diazepam being charted on the Regular Medication Chart or the PRN Medication Chart nor documented as given on the Non Packaged or PRN Administration Record. I assume that [Mr A] may have returned from A&E on June 25 with a script for Diazepam, although this is not documented on the Discharge & Coding Summary. If [Mr A] was in fact being administered Diazepam, it should have been documented (a copy of the Doctor's script is sufficient to administer from) and signed for; not to do so is unacceptable. Likewise, the Short Term Care Plan which was developed

on June 27 should have been developed on June 25 or 26 and have included any treatment recommended/commenced by A&E. I note that [Mr A] has two Regular Medication Charts — one documented and signed on 19/6/06 and the second on the 21/6/06. Also [Mr A] appears to have two PRN Medications Charts; one named chart documented and signed on 21/6/06, the second unnamed chart documented and signed on the 19/6/06 and 26/6/06. I assume the first medication chart was written by a Registered Nurse and the second one by the GP and that the first medication chart was filed away otherwise this could lead to confusion.

[Mr A's] bowel chart was commenced on 19/6/06; there is no documentation on the chart until 23/6/06 nocte despite documentation within the progress notes: '20/6/06 Am. Large bowel motion; 21/6/06 AM. BNO (bowels not open).' The Bowel Chart was only documented in intermittently and there is no clear picture obtained to assist the Registered Nurse in [Mr A's] management. The introduction of Codeine Phos[phate] (well known to cause constipation as a side effect) on the 25/6/06 by A&E and [rest home/hospital] staff from 26/6/06 would exacerbate an existing problem or cause constipation to occur unless aperients were administered with the Codeine Phos[phate]. Constipation can not only cause urinary retention or exacerbate a tendency to urinary retention but also be a factor in agitation with residents who are unable to communicate to staff that they have abdominal discomfort and are unable to pass a bowel motion. Aperients were not charted on the PRN or Regular Medication Charts and if they were available to use on the Standing Orders then they clearly were not administered to [Mr A]. It is usual practice to commence aperients at the same time Codeine Phos is commenced and I would expect the GP to have charted them. I note that when [Mr A] was transferred to [Hospital] on 29/6/06, he was noted to be constipated: 'Constipated and this managed with aperients.'

[Mr A] had five documented falls during his 11 day stay at [the rest home/hospital] from 19/6/06 until 29/6/06; two falls on 25/6/06, two falls on 26/6/06 and one fall on 29/6/06. As discussed before, no separate (from the Health and Care Assessment Form) falls assessment was completed. The Falls Policy Date of Issue December 2002 has a Nursing Assessment Post Fall Form to be completed following falls. The Protocol for the Recording and Monitoring of Falls states: 'In the event of the same Resident suffering repeated falls or accidents, they will be referred to and assessed by the doctor, physiotherapist and the primary nurse and the plan of care changed accordingly.' [Mr A] was seen on several occasions by [Dr E] but there is no evidence that a Physiotherapist was requested to review [Mr A].

On the 25/6/06, a staff member completed an Accident/Incident Form in relation to [Mr A] being incontinent on the toilet floor, wandering 5–6 times and missing from his room during the rounds and found in the dining hall. The staff member made a suggestion on an incident/accident form that a sensor mat may alert the staff when [Mr A] got out of bed; '24/6/06 Can a recurrence be prevented: ? A

sensormat may help to make the staff aware when he is out of bed.' The use of a sensor mat is excellent, especially when a resident does not, or cannot, ring the bell, as it does alert the staff when a resident is out of bed and they can then attend to the resident. Not only does this help in attending to wandering residents who require direction to the toilet, etc but also it can help prevent some falls as the staff can attend the resident while they are out of bed. In view of [Mr A's] agitation, wandering and falls on the 25/6/06 and his apparent inability to use the call bell for assistance, I would have expected a sensor mat to be placed in situ immediately as part of a risk management plan for [Mr A].

I note that on 26/6/06 the decision was made to nurse [Mr A] on a mattress on the floor, with the permission of his family, in order to prevent further falls; this appeared to be initially effective although I noted that [Mr A] continued to try and move off the mattress '(26/6/06 pm cont [Mr A] settled on mattress on floor…2200 hrs [Mr A] has not stayed on mattress. Frequently resettled)' but [Mr A] had another fall on 29/6/06. It is also unclear whether [Mr A] was continued to be nursed on a mattress on the floor. It is unusual for rest home residents to be nursed on the floor, unless they wish to do so from a cultural perspective, and I would see this as a pointer for urgent reassessment.

Observations i.e. temperature, pulse, blood pressure, were taken at the time of most of the falls and documented in the progress notes. I would expect these observations to be recorded on an Observation Form so that a clear picture could be obtained with his vital observations without having to hunt through the progress notes; there is no Observation Form as part of [Mr A's] file.

Skin tears were well documented within the progress notes and appropriately treated: '25/6/06 skin tear on back ? occipital area of head — Rt elbow — bleeding ++. Bruise and skin broken down aprox. Size of 50 cents on head. Steristriped and put interpose and gauze to apply pressure on that and secured with gauze bandage. Bleeding controlled. Rt elbow dressed with interpose steristrips and secured with crepe bandage.' Wound Dressing Change Information and Wound Monitoring Forms were completed on 25/6/06 and 26/6/06.

The steps taken by [the rest home/hospital] to manage and care for [Mr A] are mixed. The documentation within the Health and Care Assessment Form, Initial Care and Support Plan were incomplete and very limited in detail. The Short Term Plan was developed later than appropriate. The Medication Charts were documented twice and thus confusing. No in-depth assessments and subsequent care plan development were undertaken e.g. pain, continence and falls risk. [Mr A] was never formally medically admitted; there appeared to be difficulty with timeframes for the house doctor to formally admit [Mr A] and his previous GP was involved socially and formally in his care; co-ordination of care between nursing and medical staff would have been compromised by the informality of medical care. [Mr A's] agitation, attempts to climb out of a window, and

wandering did not appear to be addressed with either [the Agency] or [Dr E]. The Registered Nurses would have relied on the General Practitioner to assess and treat [Mr A's] medical needs and to refer for a geriatric assessment when required. [The rest home/hospital] did not obtain background information, including medications, about [Mr A] from his GP on admission. It is unclear how often [the rest home/hospital] staff talked with family as documentation surrounding this is limited and not in detail. [Mr A's] pain and bowels were not adequately managed.

However, [the rest home/hospital] Registered Nurses did take observations following most falls, wrote clear and comprehensive information within the progress notes. [Mr A] was sent to [Hospital] for assessment and treatment in a timely manner when this need was identified on two occasions. The intention to inform family following the fall was documented and carried through. Staff contacted [Mr A's] son informing him of [Mr A's] fall and agitation following return from [Hospital] on 25/6/06 and requested him to come and sit with [Mr A]; this was good risk management. [Mr A] appeared to receive good care physically and in a timely manner.

What standards are applicable in this case?

The standards that apply in this case are: Health Practitioners Competence Assurance Act 2003, Health and Disability Standards 2001, Nursing Council of New Zealand Code of Conduct for Nurses and Midwives 2001 and [the] District Health Board's Aged Related Residential Care Contract.

Please comment on the Rest Home's compliance with these standards.

The Registered Nurses complied with the Health Practitioners Competence Assurance Act 2003 and Nursing Council Code of Conduct for Nurses and Midwives 2001 as discussed under question No 6. Under the Nursing Council of New Zealand Code of Conduct for Nurses and Midwives 2001, the Registered Nurses met the Code of Conduct overall, but they did not ensure all assessments and the care plan reflected and met [Mr A's] needs and they could have advocated for [Mr A] with the GP by requesting him to refer [Mr A] for a geriatric assessment. [The rest home/hospital] met the Health and Disability Standards 2001 overall but could have managed the risk to [Mr A] better through the use of a sensor mat and advocacy to have [Mr A] reassessed for a higher level of care. [The rest home/hospital] did not meet [the] District Health Board's Aged Related Residential Care Contract in ensuring that [Mr A] was medically admitted within two working days of admission and by not meeting the assessment and care planning requirements.

1. What is the role of the Clinical Nurse Leader in a rest home situation? Did [Ms D] fulfil this role in [Mr A's] case?

[The rest home/hospital's] Clinical Nurse Leader/Nurse Manager role was principally being responsible for the coordination of service provision within the facility. The job description states: 'To coordinate the provision of services at [the rest home/hospital] ensuring that it satisfies residents and meets the contractual requirements…Responsible for the day-to-day coordination of [the rest home/hospital].' The role includes coordination of the residents' care, hotel services, staff management, utilisation and management of resources, information management, Team Leader for the facility, quality improvement, statistics and identifying prospective residents for community care and ongoing residential care within [the rest home/hospital] site.

The Clinical Nurse Leader/Nurse Manager role specially details the co-ordination required for residents' care. The job description states: 'Residents are assessed on admission to service by a Registered Nurse; short term Lifestyle Plan is developed within 24 hours of admission; long term individualised Lifestyle Plan is developed within 3 weeks of admission which is reviewed and updated regularly by a Registered Nurse; residents are assigned a Key Worker, who oversees their care; residents are reassessed on an ongoing basis; and 'Lifestyle Plans are evaluated 3 monthly or as residents' needs change.'

The Health and Care Needs Assessment Form appears to have been partially completed on the 23/6/06 as discussed above but has not been signed by a Registered Nurse or the Clinical Nurse Leader. The Initial Care and Support Plan, page 00075, was partially completed by [Ms D] on 19/6/06, date of admission; page 00076 was completed by R/N [Ms F] and had two dates, 16/6/06 and 26/6/06 documented on it, neither of theses dates equate with the admission date. As [Mr A] only resided at [the rest home/hospital] for 10 days, the Long Term Lifestyle Plan was not required to be completed during [Mr A's] tenure. [Mr A] did not appear to have a Key Worker assigned to him as it was not documented on the Initial Care and Support Plan or the Health and Care Needs Assessment Form. There is no documented evidence that the Initial Care and Support Plan was reviewed during the 10 days even though it was apparent that [Mr A's] needs were quite different from those identified on admission.

The Clinical Nurse Leader/Nurse Manager role states: 'Coordinates input of other health professionals into Resident care. Refers Residents on to other health professionals or agencies when necessary.' There is no evidence that [Ms D] referred [Mr A] to a Physiotherapist to meet the Protocol for the Recording and Monitoring of Falls requirement as discussed above. There is no evidence that [Ms D] discussed the difficulties [the rest home/hospital] were having in managing [Mr A's] falls, agitation and wandering with the GP and whether she requested a referral for a geriatric assessment be made. In conclusion, it is clear that [Ms D] did not completely fulfil her role in [Mr A's] case.

2. Was the [the rest home/hospital] plan of care for [Mr A] adequate and appropriate? If not, why not?

As discussed above, the format of the Initial Care and Support Plan does not lend itself to having sufficient detail documented on it to deliver appropriate care. The Health and Care Assessment Form does not provide enough of the appropriate information to use as an effective basis for the Initial Care and Support Plan or to base a long term Lifestyle Plan on. [Mr A's] falls risk should have been assessed more completely with his history of falls and recent recurrent falls; this was not done. Consequently there was not a falls risk management documented in the Initial Care and Support Plan. I note, however, that the Incident/Accident Form states: 'For Manager or Clinical Nurse Leader to Complete (within 5 days of incident) Incident related to resident cares. Specific assessments: Continence assessment, Falls assessment, Pain assessment. Had residents' lifestyle plan been updated to include new goals and interventions?' This Incident/Accident Form may be the reason why a comprehensive falls risk assessment was not completed for [Mr A]. There is no evidence that the Initial Care and Support Plan was revised and updated as [Mr A's] needs changed during his stay at [the rest home/hospital].

It was clear quite early on that [Mr A] was doubly incontinent yet a continence assessment was not carried out as a basis for a continence care plan, nor was an appropriate interim continence care plan documented. '20/6/06 nocte. 040*0 Toilet* floor wet with urine and his pyjama and bed linen (top) wet; 23/6/06 PM [Mr A] is incontinent of faeces, and its all over the carpet and incontinent of urine at 2210 hr as well; 24/6/06 0630 Incontinent of faeces x 2 Loose.' [Mr A] first complained of pain on 19/6/06: '19/6/06 pm cont Complained of pain in R knee. Knee reddened and a little swollen. Complained of pain in groin down to R knee; 19/6/06 pm he is complaining of his right leg. The knee is quite red.' There is no documentation about whether [Mr A] experienced any further pain until after his fall on 25/6/06: '25/6/06 6.45hr Verbalized painful knee … Reported pain on both knees with more on Rt) knee and pain on Lower chest along the rib margin.' [Mr A] was sent into [Hospital] as staff were concerned he had either dislocated or fractured his right hip: '25/6/06 am [Mr A's] R) hip joint/neck of femur was visible through skin — dislocated or fracture possible. Painful ++…Taken to hospital via ambulance for x-ray + assessment.' A pain assessment was not completed or an appropriate pain management care plan developed until the 27/6/06. Wound management plans were developed but were not reviewed.

Although [Mr A] was admitted as a private respite resident, he was reassessed by [the Agency] two days after admission where he was assessed as requiring rest home care and that the family would be applying for a subsidy; this placed [Mr A] under [the] District Health Board's Aged Related Residential Care Contract. [the rest home/hospital] was then required to ensure they complied with the contract in all regards; they did not comply with the Initial Care Plan, as

discussed above. In conclusion, I believe the plan of care for [Mr A] was not adequate or completely appropriate and not amended as his condition changed.

3. Should [Mr A] have been referred for a geriatric assessment soon after his admission to the rest home, and if so, why?

I clarified with [the Agency's Team Leader], who was able to refer residents for a geriatric assessment and in an acute situation; whether the Assessor involved Registered Nurses at the assessment and if it was usual for a Doctor to attend an assessment. The Team Leader informed me that a referral for a geriatric assessment must come from the Doctor. Registered Nurses can not send referrals for geriatric assessment but they can initiate an assessment by requesting the Doctor to refer to the Geriatricians. The Team Leader clarified that their Assessors would normally involve the Registered Nurse in a reassessment either by discussing the resident with the Registered Nurse prior to seeing the resident or by having the Registered Nurse present during the reassessment; Doctors were generally too busy to attend an assessment.

In [Mr A's] case, he was reassessed by [the Agency], as arranged pre admission, at [the rest home/hospital] on June 21 2006, two days after admission. It does not appear that a Registered Nurse was involved with the reassessment as [Mr A's] progress notes state: 'meeting with family, doctor, & [the Agency] today.' As above, to have the Doctor present at an assessment is unusual, though this would have certainly clarified [Mr A's] medical condition at that point of his admission. However, neither the family nor the Doctor were in a position to know how [Mr A's] behaviour changed in the evening and during the night and the reassessment would have been able to reflect these behavioural changes if the [rest home/hospital] staff had the opportunity to discuss them with [the Agency] and the Doctor. The progress notes state: '19/6/06 pm cont To be assessed physically by Dr;' there is no indication that the Doctor spoke with the [rest home/hospital] staff about [Mr A]. [Ms D's] letter states: 'The GP [Dr E] arrived at [the rest home/hospital] 1800 hours, met with the family: we were not involved my registered nurse on duty that night asked [Dr E] if he would write in [Mr A's] notes. He would not as he said it was an unofficial visit with the family. He just wanted to make sure [Mr A] was at [the rest home/hospital] of his own free will;' I assume this visit occurred on the day of admission and if this is the case it appears that the GP did not discuss [Mr A] with the Registered Nurse on duty. Because [Mr A] was not ever formally medically admitted during his stay and most of [Dr E's] visits were social and not formally documented, this would have made it very difficult for the Registered Nurses involved in [Mr A's] care as they did not have the formal support from a Doctor which they required. The progress notes state: '23/6/06 AM Will be medically admitted next week.' The Aged Related Residential Care Contract states: 'D16.5 4 Primary Medical Treatment i) You must ensure that: 1. each Subsidised Resident is examined by a General Practitioner within 2 Working Days of admission, except where the Subsidised Resident has been examined by a Medical Practitioner not more than

two Working Days prior to admission, and you have a summary of the Medical Practitioner's examination notes'. [The rest home/hospital] was not compliant with the contract.

In view of the presence of the Doctor at this reassessment and that presumably the Doctor did not see a need for a geriatric assessment, it is most reasonable for the [rest home/hospital] staff to continue caring for [Mr A], assessing him and allowing him time to settle in. However, it would have been prudent for them to have informed the Doctor of [Mr A's] behavioural changes, specifically his attempts to climb out of the window, his agitation and wandering intrusively into other residents' rooms; so that he could reassess his medication and be more informed of his care needs level. I would have expected this exchange of information and discussion around whether it would be more appropriate for [Mr A] to be assessed either by a Specialist at [the rest home/hospital] or within [the public hospital] in order to determine whether he had a medical condition causing him to be agitated, etc or a dementia with associated behaviours that required a secure environment in a rest home. As above, I note that the GP visited [Mr A] twice in a social capacity, did not document within the medical notes and therefore I assume did not give the Registered Nurse an opportunity to discuss any concerns the staff had about [Mr A] with him at those visits.

I would also expect the Registered Nurse who was the key worker for [Mr A] to have discussed [Mr A's] evening and nocturnal behaviours with the family when he was trying to climb out of the window and wandering around the rest home and informing them that [Mr A] may need to be assessed for a higher level of care than a rest home could provide if he did not settle down. There is no evidence that such a discussion occurred.

The GP could have trialled medication to see whether that would help with [Mr A's] agitation and then if there were still concerns with his behaviour, he should have referred [Mr A] for a geriatric assessment. I note that [Hospital] used PRN Haloperidol and eventually regular Respiridone to manage [Mr A's] agitation. Haloperidol is often prescribed for agitated residents and can be very effective; this is able to be prescribed by a GP; Respiridone is a medication which can only be prescribed by a Specialist.

In conclusion, I believe the GP should have discussed [Mr A's] needs and care and with the Clinical Nurse Leader or Registered Nurses during his visits to [the rest home/hospital]. I would have expected him to have reviewed [Mr A's] medication, and medically assessed him to determine why he was so agitated and falling. If [Mr A] did not respond to this intervention, then the GP should have referred [Mr A] for a geriatric assessment. I believe that the geriatric assessment should have been made soon after admission in order to determine why [Mr A] was confused, agitated and falling. There may have been a medical reason for this which could have been treated or underlying dementia and [Mr A] would have received care at the appropriate level.

4. Did [Mr A] receive an appropriate standard of nursing care for his condition over the ten days he was resident at the rest home?

Overall [the rest home/hospital] staff gave appropriate care to [Mr A] during his stay. The notes have been comprehensively documented in on every shift by carers and Registered Nurses outlining what was happening with [Mr A], their care given, risk management, instructions for supervision and their requests for further assessment of [Mr A]: '19/6/06 pm cont To be assessed physically by Dr…Cigarettes and lighters removed from his room Requires urine spec; 23/6 PM [Mr A] has been put back to his room for more than 5x times…Monitor [Mr A] please; 24/6/06 Nocte Wandering several times 8–9 times (out of bed). Each time re-orientated. Monitored him frequently; 25/6/06 6.45hr to assess and to observe; 25/6/06 2045hrs cont He had a fall at 10pm…Assessed him for meantime nothing noted at the moment. Sill able to move arms and legs and can weight bear and said that he had a bit of pain…For further assessment in mane please; 26/6/06 pm Requires close supervision.' There is good documentation from the Registered Nurses in the progress notes, evidence of good assessment and wound management following falls, '25/6/06 6.45hr skin tear on back ? occipital are of head — Rt elbow — bleeding ++ bruise and skin broken down aprox size of 50 cents on head. Steristriped and put interpose and gauze to apply pressure on that and secured with gauze bandage. Bleeding controlled…BP 140/60. Pulse 80/mt. Oriented well to staff…,' and interim risk management by moving [Mr A] near the Nurses Station and requesting the son to come and sit with [Mr A], '25/6/06 2045hrs [Mr A] couldn't be left alone as he's trying to get out even he's very weak and wobbly, put [Mr A] on the spare room near the nurses station. Settled him there. But still very unsettled trying to get out. Needs to be minded every minute. Rang [son] if he can come down to be with his dad and said he'll come down. [Mr A] wants to go home. For further assessment in mane please", and placing [Mr A] on a mattress on the floor so they could minimise his falls risk, "26/6/06 1915hrs [Mr A] settle on mattress on floor.'

There is clear evidence that [Mr A] was observed regularly (as documented above) and far more frequently than rest home residents usually require. The Registered Nurses clearly discussed situations with the Clinical Nurse Leader and obtained advice e.g. '25/5/06 Nocte. Retention of urine ++ cold compress given. No effect. Advised CNL (Clinical Nurse Leader) to get advice from A & E.' The Registered Nurses sent [Mr A] to [Hospital] on two occasions when he required assessment and care that they could not provide: '25/6/06 During cares this mane, noted that [Mr A's] R) hip joint/neck of femur was visible through skin — dislocated or fracture possible…Taken to hospital via ambulance for x-ray + assessment. 25/6/06 nocte. Retention of urine ++…shift to A&E to catheterize. Ambulance called and shifted to hospital at 03:15 hrs. Son accompanied him in ambulance. He was unable to stand/walk looks in pain.'

However, [Mr A's] pain levels were managed on a PRN basis and it appears from the documentation on the Non Packaged or PRN Administration Record

that he only received Panadol (Paracetamol) on five occasions '19/6/06 2030, 25/6 0715, 25/6 1100, 26/06 0900, 26/6 1930' and Codeine Phos on two occasions '26/06 60mg (?) 23:30, 27/6 60mg 1230.' The progress notes stated: '26/6/06 AM So much pain…pm Dr examined [Mr A's] legs….Has prescribed Paracetamol 2 tabs PRN for pain; 27/6/06 AM he was in a lot of pain on his legs…pm S/B Dr E 1800hrs…Dr has prescribed Codeine 30mgs BD for pain…Diazepam discontinued.' I note that the Panadol was given from Standing Orders prior to the GP's prescription on 27/6/06 and that [Mr A] received 60mg of Codeine on the 26/6/06 and 27/6/06 prior to the GP's prescription or 30mg Codeine BD (twice a day) and did not appear to receive any more Codeine despite the fact that the GP charted it as a regular medication. I am not sure why [Mr A] was given Codeine when it wasn't charted and I can only presume that the 60mg of Codeine was given from standing orders but cannot confirm that as I haven't got a copy of the standing orders to check. It is well known that Paracetamol is given four times a day on a regular basis to control pain and that other analgesic medication is added on top of this; I am not sure why the Registered Nurses did not give [Mr A] more regular Paracetamol to try and control the pain he was experiencing; [Dr E] clearly expected [Mr A] to have the Paracetamol regularly as he documented in the medical notes '27/6/06 To have Paracetamol 2 4hrly–6 hrl' even though he charted it as PRN. I note that the GP discontinued Diazepam which I assume was prescribed following [Mr A's] visit to A&E on 25/6/06 as they treated him there with Diazepam. I could not find any evidence of the Diazepam being prescribed nor signed as being given, yet he must have been on it as it is documented as being discontinued.

[The rest home/hospital] had 9 residents with the facility's hospital having 31 hospital beds. Rest homes do not require a Registered Nurse to be on site 24-hourly and there is no set amount of Registered Nurses hours legally required. [The rest home/hospital's] Clinical Nurse Leader, [Ms D], was overseeing clinical care for both rest home and hospital residents. The hospital requirements are that there is one Registered Nurse on at all times. Clearly the hospital Registered Nurses had significant input into the rest home residents, as evidenced by [Mr A's] progress notes through the 24 hour periods. [Mr A], therefore, had more Registered Nurse input than normal during his stay at [the rest home/hospital].

In conclusion, [Mr A] did receive an appropriate standard of care overall from [the] Registered Nurses and carers within the confines of lack of formal medical input and the level of care a rest home could provide, however, [Mr A's] pain levels were not managed adequately.

5. Please comment on [Ms D] and [Ms C's] responses concerning the urgency of [Mr A's] initial admission to the rest home.

[Ms D's] response

[Ms D] has expressed that [Mr A's] admission to [the rest home/hospital] was urgent: 'On the day of the 19th June, [Mr A's daughter-in-law] rang me, frantic to find a private bed for her father-in-law. [Mr A's] sons and daughter-in-law were very concerned for him as he was not showering or changing his clothes. Furthermore, [Mr A] was not eating just smoking and sitting in front of the heater…[Mr A's] admission was an urgent request from a family who were desperate. Our procedure is usually via a [the Agency] referral, but can be from a personal family request….[the Agency] was familiar with [Mr A], and his family, as help in the home had been arranged. However, we were advised that [his daughter] had cancelled all home help'...The arrival of [Mr A] at [the rest home/hospital] was of some urgency, and occurred amidst conflicting stories as to his needs.

It appears that there were differences of opinion within [Mr A's] family about his admission to [the rest home/hospital]. [Ms D's] response also states: 'Approximately 1 hour later [Mr A's] daughters arrived. They were not pleased about his admission…The GP [Dr E] arrived at [the rest home/hospital] 1800 hours, met with the family; we were not involved…He just wanted to make sure [Mr A] was [there] of his own free will; Due to the urgency of [Mr A's] admission, and the conflicting history given by various members of his family…Once admitted it became obvious his daughters voiced different views of [Mr A's] wellbeing than the sons and daughter-in-law who brought him in to [the rest home/hospital].'

[Ms C's] response

[Ms C] outlines in her letter that she was on annual leave when [Mr A] was admitted to [the rest home/hospital] and that she could only make comments based on discussion with staff and by reading the notes. 'Unfortunately I was on annual leave at the time of [Mr A's] admission, so do not have first hand knowledge of what occurred. I can only advise what occurred through discussions I have had with my staff and through the medical file. I am told that initially [Mr A] was to be private respite because [Mr A] was not able to look after himself at home and family were not able to provide that care or safety needed. This was agreed by [Ms D]…with the [daughter-in-law], who happened to be a staff member at [the rest home/hospital] at the time, as a favour to them. The admission was rushed.' She appeared to understand that [Mr A's] private respite admission was rushed and he was admitted as a favour to the family.

It is not uncommon for urgent situations to occur for elderly people living at home and for them to be admitted urgently to a rest home on respite care.

Usually they are admitted with funded respite care rather than privately paid respite; [the Agency] would have needed to assess [Mr A] for respite care and if respite care had not already been put in place, [the Agency] would have needed to assess [Mr A] for the need for respite. If respite is already in place the admission could be on the day of request or the next day if family are with the elderly person. This admission appeared to be rushed at the instigation of the family and this could be the reason why [Mr A] was admitted privately rather than with funded respite.

Of note is that [Mr A's] daughter in law was a [staff member] and that it appeared [the rest home/hospital] accepted [Mr A] on private respite as a favour to her.

6. Please comment on the manner in which the rest home managed the concerns raised by [Mr A's] family.

There is little documented evidence within the progress notes that the family had been raising concerns with the staff. The response from the Manager dated 16 March 2007, the Clinical Nurse Leader received 23 March 2007 and the relieving Manager dated 22 November 2006 to the Health and Disability Service, and the letter to family from the Manager dated November 3 2006 address family concerns raised. I will comment on the concerns the family raised through their letter of complaint to the Health and Disability Commissioner and the comments made through the above mentioned communications.

[Mrs B], [Mr A's] daughter, made contact with the Manager of [the rest home/hospital] in October 2006 and raised her concern about [Mr A] not being sent to hospital quickly enough and asked for the on duty staff members names: 'She said she was concerned that we didn't act quickly enough to get him to hospital…She said she did not wish to make a complaint but just wanted to know who was on duty and what had occurred regarding her fathers fall and [Hospital] admission on that day.' [Ms C] then underwent an investigation and contacted Mrs B to discuss her concerns and also responded to her via a letter dated 3 November 2006. The letter states: 'I am informed by [Ms D] that she tried to get a doctor for your Father on the morning of this incident and finally [Dr E] agreed to come as he knew your Father and as a favour to [Ms D] as he had stated previously that he did not wish to see Residents in our Rest Home and Hospital once admitted…As far as we are aware we booked an ambulance to come and this arrived at 1430hrs to take him to [Hospital]. If your Father's condition had been critical the Doctor would have requested a faster response time from the ambulance.' When booking an ambulance to transfer a resident to hospital they always ask if it is urgent or as soon as they can come. The need for either an urgent immediate response is always identified at the time or else the facility waits until the ambulance is able to attend. The Manager is correct in that if [Mr A's] condition was critical, the GP would have requested an immediate response from the ambulance.

The family had documented in their letter to the Health and Disability Commissioner that [Mr A] was admitted for respite care with a urinary complaint. The progress notes on admission describe a history of blackouts, not eating and not taking medication along with the family feeling [Mr A] had deteriorated over the last few weeks and also queries whether [Mr A] was incontinent of urine with family unsure. 'Dad was only admitted to [the rest home/hospital] for a Urinary complaint as respite care.' '19/6/06 1415 [Mr A] has a history of not taking his medication, not eating meals. Coffee and a smoke for dinner…History of blackouts family feel he has deteriorated over the last few weeks…? Incontinent of urine family unsure.' The [the Agency] Reassessment states: 'Events leading to Reassessment: Has been having recurrent falls. Previous Hx (History) of falls, blackouts, cardiac disease, hypertension.' Clearly [Mr A] was not admitted for a urinary complaint. He became incontinent of urine and eventually went into urinary retention on 26/6/06. [Mr A] did not have a continence assessment but was appropriately managed with pads until [Mr A] went into retention. The urinary retention was appropriately managed by [the rest home/hospital] when they sent [Mr A] into [Hospital] for catheterisation as discussed above.

Family letter states: 'On June 25 2006, I [Mrs B], phoned [the rest home/hospital] at 10.15AM and staff handed my father the phone and Dad said "I really hurt"…I asked him to pass the phone to a nurse. I requested that she possibly…look at Dad and she told me that he had dislocated his hip and that he had had a fall at 6.45AM.' The [the rest home/hospital] progress notes states: 25/6/06 6.45AM Found him walking towards — and told that he had a fall…To inform family mane by RN; 25/6/06 AM During cares this mane, noted that [Mr A's] R) hip joint/neck of femur was visible… — dislocated or fracture possible…family informed + visited by 3 siblings.' [the rest home/hospital] have clearly informed the family, but I am unable to comment as to whether the staff phoned the family to inform them or just informed them when the family phoned [Mr A]. [the rest home/hospital] appropriately managed [Mr A's] queried dislocated or fractured hip by sending him into [Hospital] for X-ray and assessment as previously discussed.

'[My brother] received a phone call at midnight to say Dad's not well and at 3 AM [he] accompanied him to [the] DHB. [The rest home/hospital] Nurse said to [my brother] that she could not insert a catheter because she had never done that procedure in a man before and that he would have to go to hospital. Comment from hospital staff was that they had never heard of that before. [The rest home/hospital] progress notes states: 25/6/06 2045 cont [Mr A] couldn't be left alone as he's trying to get out even he's very weak and wobbly…Rang [son] if he can come down to be with his Dad and said he'll come down…nocte Retention of urine ++…Advised CNL to get advice from A&E and A&E staff advised to shift to A&E to catheterize. Ambulance called and shifted to hospital at 03:15hrs son accompanied him in ambulance.'

There is no documented evidence that the Registered Nurse discussed not being able to catheterize [Mr A] and why she/he could not, however, one could make the assumption that this was discussed with the son. It is well known within the health sector that it is not usual practice for Registered Nurses to catheterise male residents unless they have been specially trained to do it and that Registered Nurses must be competent in any procedures they undertake, meet their scope of practice and the requirements of the Health Practitioners Competence Assurance Act 2003. Traditionally only Doctors and male Registered Nurses catheterized male patients for many years within the health sector and there are large numbers of female Registered Nurses who have never catheterized a male patient. Any Registered Nurse who has been trained and is competent to catheterize a male patient may do so. In [Mr A's] case, if the Registered Nurse was untrained in this procedure then the correct action was taken to send [Mr A] to [Hospital] for this procedure.

'Next day June 26, 2006 he had a catheter inserted and was returned to [the rest home/hospital]. His General Practitioner [Doctor E] came to see him because he was in great pain and not able to walk, subsequently he never walked again.'

[The rest home/hospital] progress notes states: '26/6/06 AM Very unsteady as well on his legs…pm S/B Dr E at 1830 hrs. Dr said it was an unofficial visit and declined to write in Medical notes…[Daughter] present. Dr Examined [Mr A's] legs said he could not find anything wrong. Has prescribed Paracetamol (2) tabs PRN for pain…[Mr A] able to stand with assistance, complained of pain R leg; 27/6/06 AM Standing him up today with [a caregiver] and he was in a lot of pain on his legs'. The medication chart states: '26/6/06 Paracetamol 2 tabs 4–6 h[ou]rly oral PRN.' Paracetamol is a baseline analgesia and is usually prescribed regularly rather than PRN (as required) for someone who is experiencing significant pain. There are other medications which could be prescribed at this point to give further relief from pain. [Mr A] had another fall immediately after the GP left; subsequently he was nursed on a mattress on the floor as commented on above.

He was reviewed by the GP again on the 27/6/06 at 1800 hrs when the GP referred him for an x-ray; the family were present at this visit: '27/6/06 pm S/B [Dr E] 1800 hrs. family present. [Mr A] to have an X-ray of his knees tomorrow.' Medical progress notes states: 'Came to see pt on request of family & rest home staff as he was noted to be not well…has been seen 2x at [Hospital] A&E & X-ray done. No # (fracture) noted. Has continued to c/o pain on bearing weight & now unable to walk…No pain elicited from the hip. The Rt knee it was very tender — esp along the joint lines medically & also in the back of the knee ROND (?) — Reduced due to severe pain. Imp Injury to Rt Knee ? #...Plan X-ray Rt Knee.' [Dr E] also reviewed [Mr A] on 29/6/06 with the family present. His documentation in the medical continuation notes states: 'Our concern is probably his sudden deterioration and ? delirium and his inability to bear wt at all despite No # being detected.' The family were present at both examinations and I

presume would have been informed by the GP what possible diagnosis he was thinking and his plan to X-ray the knee in order to confirm or rule out this possible diagnosis for the visit on 27/6/06 and that the GP was clearly at a loss to determine what the problem was that was causing [Mr A] to be unable to weight bear on the 29/6/06 visit. This is substantiated by [Mrs B] and [Mr A's daughter's] letter to the Health and Disability Commissioner's office, page 00110, where it states: 'We were there in Dad's room from just after 10am until he was transferred to [Hospital] at [Doctor E's] referral, subsequently we knew exactly what was happening.'

'Sent for X-Ray on June 28, 2006 which family believed was possibly a fracture hip (nurse from [the rest home/hospital] said that he had a huge haematoma which disappeared possibly causing the internal bleeding and pain).'

There is no documentation in the progress notes to substantiate or disprove this statement so I am unable to comment about what possible statement a nurse may have made to the family, however, as discussed above, the family were present when the GP reviewed [Mr A] on the 27/6/06 where I presume the GP would have explained to the family the possible diagnosis and his management plan.

'[A rest home/hospital] staff member phoned [my sister Mrs B] at 9.30AM asking her to go down to [another area], which takes an hour pick Dad up by car and take him [to Radiology] at 11.30. [The rest home/hospital] would not authorise the use of their Mobility Van and our father cried in pain as we lifted him in and out of our car. Dad could not stand or even sit during the X-Ray.'

Under the Aged Care Residential Contract [the rest home/hospital] is obliged to meet the costs of transport to Radiology Services but may request the family to take the resident there. The contract states: 'D20.1 You must ensure that each Subsidised Resident has access to the services, listed in this clause, as required by the assessed need of each Subsidies Resident: e) Radiological services. D20.2 You must meet the costs of transport, including specialised transport required for clinical reason, to the services in clause D20.1 (a) to (h); D20.4 Accompanying Subsidised Residents. As part of the Services you will: a) Use your best endeavours to ensure that Subsidised Residents re accompanied to such appointments by an appropriate relative or friend'. It is common practice for rest homes to allow the family the opportunity to not only accompany the resident to an appointment but also take them. Should the family not be able or wish to take the resident then the rest home must ensure that they organise and take the resident to the appointment. There is no documentation within the progress notes surrounding this issue.

The letter of complaint outlines the following issues:

1. *We weren't notified about his fall and it was a lengthy time between 6.45 am and 10:15 AM to examine his hip upon my request only.*

As discussed earlier, the night Registered Nurse documented the fall [Mr A] reported he had had and stated: '25/6/06 6.45hr to inform family mane by RN.' The progress notes for the morning states: 'family informed + visited by 3 siblings.' There is no time documented by the morning Registered Nurse so I can't comment on the time frame for her notification. It is common practice for night staff not to inform family of falls if there does not appear to be an immediate need for assessment for a fractured hip. It would have been prudent for [the rest home/hospital] to have a form, signed by the family, addressing the issue of when family would like to be informed for any falls.

2. *Concerning incident on June 28, 2006, we cannot understand why staff allowed him to experience all those transfers without offering an Ambulance or the use of the van or assistance in lifting.*

In view of the fact that [Mr A] was agitated, confused, trying to stand up and falling, had a catheter insitu, had an X-ray for a possible fracture of the knee and had difficulty weight bearing, I believe that [the rest home/hospital] should have sent [Mr A] in an ambulance for the X-ray.

3. *On June 29, 2006 concerning the broken nose incident staff did not call a doctor and when asked by us to phone for medical help they told us that they couldn't get anyone to look at him for two days. We took action and [Dr E] called and summoned an Ambulance.*

[Mr A] fell on 29/6/06 at approximately 9.30 am and sustained a skin tear on his nose as discussed below under concern number 7. There is no evidence to substantiate that [Mr A] suffered a broken nose or that this possibility was discussed with the GP. The GP's [the rest home/hospital] medical continuation notes documented on 29/6/06 do not mention the nose and states the following: 'He is complaining of severe pain in his left knee with Rt thigh back and Lt hip. The family has also noted that he is sleeping a lot as well. They are very concerned as to why he is not walking and how best to make him safe and prevent these falls.' The [Hospital] Discharge & Coding Summaries dated 29/06/06, 11/07/06 and 20/07/06 do not mention a broken nose as one of the diagnoses documented. [Rest Home 2] documentation also does not list a broken nose as one of [Mr A's] diagnoses. There is no documentation within [Mr A's] progress notes about any attempts or difficulties in obtaining a Doctor to review [Mr A], they state: '[Dr E] reviewed [Mr A]. Family in attendance. Dr referred [Mr A] to Medical Registrar at [Hospital]. Was transferred via ambulance at 1430. Is for further assessment and investigation into causative factors of numerous falls.' [Dr E's] documentation on 29/6/06 states: 'Called in by relatives to see [Mr A] because he appears to have had a few more falls last night or this morning….Chest A&E reduced slightly ?? bilat and there appeared to be some crackles of the bases ?? There is also occ exp wheeze noted as well…Our concern is probably his sudden deterioration and ? delirium and his inability to bear wt at all despite no # being detected. D/W Med Reg — To be seen in A &

E by Med Reg and further Mx decided.' [Dr E] had previously seen [Mr A] on 27/6/06 and ordered x-rays as part of his investigation into [Mr A's] mobility and pain issues. He did not appear to see the need for a referral to [Hospital] at that stage but made the decision on 29/6/06 as [Mr A] continued to fall, have pain and he had concerns about his chest.

4. *[Rest home/hospital] Staff had not approached us through the process nor had they since enquired as to Dad's health.*

This is difficult to comment on as I am not sure which timeframes are being referred to. It is usual for the facility to enquire about a resident from both the hospital, in this case [Hospital], and the family during the time they have been sent in for assessment and management. However, once the resident has moved to another facility, it is not common practice for a facility to follow up with family, nor would they once the Health and Disability Commissioner is involved.

5. *Upon request for answers about Dad's supposed fall staff kept away and refused to talk to us except for [a registered nurse] who came before the Ambulance left because she was required to sign the release form from the rest home for [Dr E].*

It is the responsibility of the Registered Nurse or the Clinical Nurse Leader, not carers, to discuss a resident's health status with family. The carers were appropriately not speaking about clinical matters with the family and I would assume they referred the family to the Registered Nurse. I also assume that [the registered nurse] was the Registered Nurse on duty at the time and it was appropriate for her to speak with the family. I note that in the Manager's letter dated 16 March 2007, she states: 'the discussions I had had with the RN on that morning, [name]' and appears to validate my assumption.

6. *October 16, 2006 I have requested the names of staff members on duty attending [Mr A] according to his Medical File and [Ms C] was guarded with me and has been tardy with returning any information which could have been given at the time of the call. She stated privacy and asked if I was going to lay a complaint and said, 'of course I only hear second hand'.*

It is appropriate that [Ms C] did not release staff members' names to family for privacy reasons. It would be reasonable for the Manager and Clinical Nurse Leader to have met with family, gone through [Mr A's] file with them and discussed any concerns the family had. It would also have been reasonable to have asked the GP to be present, if he were able, in order to answer any medical query the family may have had.

7. *Please note the enclosed photos including the one with the extra full urine bag and the distance that this bed bell was from him along with last night's tea dishes. From the photos which we took showing dinner dishes from the previous*

night Dad was not given breakfast, morning tea or lunch and a recent explanation by [Ms C], Manager stated that Dad had fallen at 9.30 AM on June 29, 2006 which we refute because we arrived at 10:00AM approximately.

Urinary output is managed overnight by attaching a night bag onto the day bag and removing it approximately 7 am each morning. I note the time the photo was taken of the reasonably full day bag was approximately 10 am. Three hours from removing the night bag and leaving the day bag empty is a reasonable timeframe for the day bag to fill up again and would indicate that [Mr A] was receiving adequate fluid intake. The progress notes document that [Mr A] had a fall at 0930 approximately and detail observations and wound dressings applied. The Registered Nurse clearly prioritised her care of [Mr A] by attending to his needs from the fall. 'fall at 0930 (approx) BP 120/70, temp 36.5 C, pulse 79bpm, RR 18. Sustained S/T to for head, nose and L) hand. Redressed L) elbow S/T from previous fall.'

It is difficult to clearly see the call bell but it does appear to be on the floor. Various reasons could explain this i.e. it fell off the bed with [Mr A's] agitation and movement in the bed or was not given to [Mr A]. If it wasn't given to [Mr A] it may have been because in his confusion he was unable to use it. It would have been more appropriate to have a sensor mat in place so that staff were alerted when [Mr A] got out of bed.

The photos showing dinner dishes from the previous night have not been sent to me. I would find it hard to believe that a resident would not be offered food and fluids. As above, the fact that the day bag was reasonably full implies that [Mr A] was well hydrated and had received plenty of fluid.

The family have refuted that [Mr A] could have fallen at 9:30AM as they arrived at 10:00AM approximately. The progress notes state that [Mr A] fell at approximately 0930, as stated above, and a half hour is sufficient time to pick [Mr A] up off the floor, take his observations and attend to his skin tears. My assumption is that [Mr A] was found on the floor at approximately 9.30 am.

8. *Our father died of internal haemorrhaging causes unknown at [Rest Home 2] on […].*

[Rest Home 2] information on page 00181 states the following causes of death: 'Causes of Death — Respiratory and circulation failure — minutes; Chronic obstructive lung disease — many years; Hypertension — many years; Bedridden — one month; Haematuria: cause — 10 days; Renal impairment — one month; Urinary Retention due to prostate hypertrophy — one month.'

I note that [Rest Home 2] has identified several causes of death for [Mr A], one of which is haematuria. Haematuria can occur with urinary tract infections which may have been the cause of this haematuria, however this concern is best

answered by a Doctor who has access to [Mr A's] medical file during his stay at [Rest Home 2]. [Mr A] was transferred from [the rest home/hospital's] care on 29 June 2006, three months prior to his death at [Rest Home 2].

In conclusion, there is no evidence that any concerns were raised to [the rest home/hospital] by the family during [Mr A's] stay as there is no documentation. Family raised concerns to the Manager who instigated an investigation as she was not present during this time and was unaware of what had occurred. The Manager then contacted the family to discuss the findings. I believe that [the rest home/hospital] could have invited the family to a meeting to discuss the concerns face to face, and to include the Clinical Nurse Leader and the GP, if he was available, to answer specific questions. However, [the rest home/hospital] Manager did follow-up with the concerns raised and reported back to the family and sent a letter outlining what had been discussed and apologising for the communication offered to the family regarding Mr A. [the rest home/hospital] Manager appeared to make a genuine effort to investigate and discuss the concerns with the family; however, it could have been handled differently with personal interface between the parties.

Are there any aspects of the care provided by the rest home/hospital that you consider warrant additional comment?

I believe that overall [Mr A] did receive good care and attention from [the rest home/hospital] staff with good documentation on his clinical care within the progress notes. [the rest home/hospital] could have improved their care by communicating well with the family and documenting such communication at the time as well as advocating for the GP to refer [Mr A] at an earlier stage. I would like to add that when referrals are sent through for reassessment, there is normally a delay before the team can come and assess the resident, so if the referral had been sent earlier, rather than a phone call to admit [Mr A], there may well have been a delay of several days.

Appendix 2

Information reviewed by Ms Jenny Baker Expert Advisor:

Complaint

Please comment on the steps taken by [the rest home/hospital] to manage and care for [Mr A] from his admission on 19 June 2006 to his transfer to [Hospital] on 29 June 2006.

What standards are applicable in this case?

Please comment on the Rest Home's compliance with these standards.

If not commented in above, please provide advice concerning the management of the following matters, giving reasons for your opinion:

1. What is the role of the Clinical Nurse Leader in a rest home situation? Did [Ms D] fulfil this role in [Mr A's] case?
2. Was the [the rest home/hospital] plan of care for [Mr A] adequate and appropriate? If not, why not?
3. Should [Mr A] have been referred for a geriatric assessment soon after his admission to the rest home, and if so, why?
4. Did [Mr A] receive an appropriate standard of nursing care for his condition over the ten days he was resident at the rest home?
5. Please comment on [Ms D] and [Ms C's] responses concerning the urgency of [Mr A's] initial admission to the rest home.
6. Please comment on the manner in which the rest home managed the concerns raised by [Mr A's] family.

I have been provided with one Bundle of Documents and information I requested faxed to me listed as the following:

Bundle of Documents:

Information from HDC as follows:

2. Complaint letter dated October 16 2006.(A)
3. Letter dated 28 February 2007 to Complainant.(B)

Information from [the Agency] (C) as follows:

4. Support Needs Reassessment and SNL Level from [the Agency] dated 21/6/06.
5. Fax dated 19/6/06 from [the Agency] to [the rest home/hospital].
6. Support Needs Assessment dated 19/4/05 from [the Agency].

Information from [the rest home/hospital] (D) and (E) as follows:

7. [The rest home/hospital] Admission Form dated 21/6/06.
8. [The rest home/hospital] Consent Form dated 20/6/06.
9. Liten-Up Handling Programme dated 20/6/06.
10. Admission Checklist dated 19/6/06.
11. Orientation of New Residents to [rest home/hospital] Facilities Procedure Checklist dated 19/6/06.
12. Personal Details Form.
13. [The rest home/hospital] Care Progress Notes.
14. Referral from Dr E to the on-call medical registrar at [Hospital] A&E dated 29/6/06.
15. Incident Forms dated 28/6/06, 26/6/06, 26/6/06, 25/6/06, 25, 24/6/06.
16. [The rest home/hospital] Initial Care and Support Plan dated 19/6/06 and 16/6/06.
17. Short Term Care Plan dated 27/6/06.
18. Health and Care Needs Assessment dated 19/6/06.
19. Resident Profile, no date.
20. Regular Medication Sheet dated 21/6/06.
21. PRN Medications Chart dated 21/6/06.
22. Medication Administration Record signing sheet, no date.
23. Non Packaged or PRN Administration Record.
24. Unnamed "medication chart".
25. Regular Medication Sheet dated 19/6/06.
26. Hydration Chart dated 26–29/6/06.
27. Bowel Chart.
28. Wound Dressing Change Information chart dated 25/6/06.
29. Wound Monitoring Form dated 25/6/06.
30. Wound Dressing Change Information chart dated 26/06.
31. Wound Monitoring Form dated 26/06.
32. [Hospital] Discharge & Coding Summary Emergency Dept dated 25/6/06.
33. [Hospital] Discharge & Coding Summary Emergency Dept dated 26/6/06.
34. [Hospital] Discharge & Coding Summary Emergency Dept dated 25/6/06. (same as no 31).

Information from HDC as follows:

35. Letter of response from [the rest home/hospital] Acting Manager dated 22 November 2006 (F).

Information from [the rest home/hospital] General Manager — Operations (G) as follows:

36. Letter from [the] General Manager, Operations dated 7 March 2006.
37. Village Manager Position Description.
38. Nurse Manager Position Description.

39. Pre Entry Screening of New Facility Residents Policy and protocols.
40. Pre-Entry Assessment Form.
41. Falls Policy, protocols and forms.
42. Incidents/Accidents and Hazard Reporting, procedures and forms.

Information from HDC (H) as follows:

43. Letter from Nurse Manager no date but received 23 March 2007.
44. Letter from Nursing Council of New Zealand dated 6 March 2007.
45. Nurse Record Summary printed 06/03/2007.
46. Letter Previous Manager, [the rest home/hospital] dated 16 March 2007 (I).

Information from General Practitioner (K) as follows:

47. Letter dated 26 Feb 2007.
48. [Rest Home 2] request for medical notes received 11 Aug 2006.
49. Fax from X-Ray Department [at the] Hospital dated July 20, 2006.
50. Letter from [the Agency] dated Friday, 23 June 2006.
51. Consultation note dated 8 Aug 2006, 12 Jul 2006, 26 Jun 2006.
52. Inbox Report dated 7 Aug 2006, 01 Aug 2006, 26 Jun 2006.

Information from [Hospital] (J) as follows:

53. Discharge & Coding Summary Emergency Dept dated 25/06/2006.
54. Discharge & Coding Summary Emergency Dept dated 26/06/2006.
55. Discharge & Coding Summary Medical dated 10/08/2006.
56. Discharge & Coding Summary Spec Rehab Over 65 yr dated 01/08/2006.
57. Discharge & Coding Summary Medical dated 07/08/2006.
58. ACC Injury Claim Form dated 03/07/2006.

Information from [Rest Home 2] (L) as follows:

59. Two page overview of [Mr A's] stay at [Rest Home 2]

Information faxed from Health and Disability:

[The rest home/hospital] Clinical Nurse Leader/Nurse Manager Job Description.

Expert advisor's chronology of events

19/6/06 Emergency admission to [the rest home/hospital]

19/6/06 PM. Became agitated after dinner and tried to climb out of the window. Mistaking drawers for a door. No Accident/Incident Form completed for attempt to climb out of window. Complained of pain in R) knee, in groin down to R) knee. For urine specimen.

19/6/06 Nocte. Very confused with unsteady gait. Wandering to other residents.

20/6/06 Nocte. Confused and wandering through hallway.

21/6/06 Am. Meeting with [the Agency], family and doctor.

23/6/06 AM. Very confusing, disorientated and wandering.

23/6/06 AM. For medical admission next week.

23/6/06 PM. Very confused, disorientated. Doubly incontinent.

24/6/06 Nocte. Wandering constantly (8–9 times out of bed). Missing on 2am round and found in dining hall. Incontinent of urine and on floor, later incontinent of faeces.

24/6/06 AM. Very confused.

24/6/06 PM. Registered Nurse spoke with son who informed RN that "he lost the plot before he came here".

25/6/06 Nocte. Wet toilet floor once during night. Found at 6.45am walking and told RN that he had fallen. Walking with some difficulty. Painful knee, skin tear back of head and R) elbow, bruise and skin tear on head. Complained of pain in both knees and lower chest along rib margin. Family to be notified in morning. No signs of fracture but with limited movement of R) leg. Accident/Incident Form completed and describes sensor mat put insitu.

25/6/06 AM. Noted to have R) hip joint visible through skin. Family informed and visited. Sent to [Hospital] via ambulance for X-ray and assessment. Given Diazepam, Paracetamol and codeine by Emergency Department with good relief from Diazepam.

25/6/06 1810. [A] Hospital Doctor phoned for information. RN informed [Mr A] did not have a fracture. To stay in hospital for pain management.

25/6/06 2045. [Mr A] returned to [the rest home/hospital] via ambulance with family. Fall with skin tear L) arm and hand at 10pm. Moved to room next to Nurses Station. Accident/Incident Form completed. [Mr A] attempting to get up continuously. Son phoned and requested to come and sit with him.

25/5/06 Nocte. Son present and stayed with [Mr A]. Codeine Phos given for pain relief. Retention of urine noted. Clinical Nurse Leader asked for advice — to get advice from A & E (Accident & Emergency). Sent to [Hospital] via ambulance for catheterisation at 03.15 hrs.

26/6/06 AM. Arrived back from [Hospital] at 0730 catheterised. Visible haematuria (blood) in day bag. Very agitated and restless, trying to pull catheter out. Accident/Incident Form completed for fall at 1000 but no documentation of fall in progress notes.

26/6/06 PM. Seen by [Dr E] at 1830 on unofficial visit, no documentation in medical notes. Examined [Mr A's] legs and found nothing wrong.

26/6/06 1915. [Mr A] found on floor just after GP left. Complained of pain R) leg. [Mr A] placed on mattress on the floor. Continued to get up off mattress. Accident/Incident Form completed.

27/6/06 AM. Experienced a lot of pain. Given Codeine Phos 60mg and Paracetamol for pain, remained in pain. For visit by Doctor at 5pm.

27/6/06 PM. Seen by [Dr E] at 1800. For X-ray of knees tomorrow. Codeine Phos 30mgs BD charted by Doctor. Diazepam discontinued.

28/6/06 AM. Taken to X-ray by daughters. Spent the day in a wheelchair.

29/6/06 AM. Fall at 0930 approximately with skin tears to head, nose and L) hand. Reviewed by [Dr E], family in attendance. Referral to [Hospital] Medical Registrar and transferred via ambulance at 1430 for further assessment and investigation into causative factors of numerous falls. Urine specimen result negative. No Accident/Incident Form completed."

Appendix 3

The Commissioner's clinical advisor, Dr Stuart Tiller, a GP with vocational registration, was asked to review the records. On 22 December 2006, he advised as follows:

> "[Mr A] should never have been accepted by [the rest home/hospital] given his unstable clinical situation, without confidence that they could provide adequate medical services to him from a contracted GP. Adequate services would include emergency cover out of surgery hours. It is apparent that [the rest home/hospital] could not provide the medical care required and thus presumed upon the good will of [Dr E]. Having accepted [Mr A] as an in-patient, it is my opinion that it soon became apparent that he required urgent medical assessment for the urinary problems with which he was admitted, his confusion, and his falls. Given that medical attention could not be sourced by the rest home, and that his situation was deteriorating by the day, it is my opinion that it was the responsibility of the clinical nurse leader to provide both clinical direction to the nursing staff and leadership in making clinical management decisions. [Mr A] should have been transferred to hospital within the first three days of his admission to [the rest home/hospital] given his confusion, falls for which the cause was unknown, and urinary incontinence, in the absence of adequate medical review or ongoing medical supervision.
>
> There were also individual nursing actions that were less than acceptable. On 25/6/06 [Mr A] was left sitting on a commode unsupervised while a nurse completed her 'pill round'. The nurse told him 'just stay on commode and I will get back to him.' [Mr A] fell and sustained lacerations to the arm and hand. This nurse then moved [Mr A] to a room near the nursing station to facilitate observations. This nurse suggested 'for further assessment in the morning please.' There is no entry in the clinical records to indicate that the clinical nurse leader read or took any action on this request the next or any other day.
>
> [Mr A] had been nursed on a mattress on the floor but was placed in bed after his fall of 29/6/06 but with no cot-sides in place. A photograph indicates that the call bell was out of reach on this occasion and apparently on other occasions also. A blood stained towel was left lying in the bathroom. This should have been placed in a linen bag for contaminated materials. Blood spots on the carpet should have been covered if they could not immediately be removed by cleaning staff. These matters tend to suggest that clinical standards were not being observed adequately by the nursing staff or enforced by the clinical nurse leader to an adequate standard.
>
> It is my impression from a review of the clinical records that there is no evidence to suggest 'abuse' of [Mr A] but it is my opinion that nursing standards and

systems at [the rest home/hospital]were of an inadequate level for the particular and acute medical needs of [Mr A].

Regarding the specific concerns raised by the family:

The morning nurse on 25/6/06 wrote that 'family were informed and [Mr A] was visited by three siblings.' This is at variance with the statement of his children who believe that they discovered the fall when a daughter telephoned and spoke with her father who was audibly distressed after the fall.

It is my opinion that it was an inappropriate management decision to refuse transportation to the radiology unit on 28/6/06 in [the rest home/hospital] mobility van. Further, a nurse escort was warranted. [Mr A] had an indwelling catheter, and the previous evening had been noted to be 'in a lot of pain on his legs'. The family had admitted [Mr A] to [the rest home/hospital] because they could no longer manage his needs. These included confusion, mobility and falls. It was inappropriate to allow family members to take [Mr A] to the radiology department given his clinical state and needs level SNL 4 at that time.

A photograph taken on 29/6/06 does indicate that [Mr A] was asleep in bed and looked unwell. He had obvious bruising on the forehead and dressings on the nose and forehead areas. The photographs do not show 'pools of blood on the carpet' but rather a number of spots of blood are visible. 'A blood stained towel was left lying in the bathroom.' This should have been placed in a linen bag for contaminated materials. Blood spots on the carpet should have been covered if they could not immediately be removed by cleaning staff. Also, as previously stated, it was unacceptable for [the rest home/hospital] to be treating a patient with the unstable medical state of [Mr A] without a system in place for emergency provision of medical attention from a doctor.

It is unclear if the fall of 29/6/06 was witnessed. There was no reason for staff to withhold information from family members.

Dr Tiller was asked to provide further advice in response to Ms Baker's comments about the lack of formal review. On 11 July 2007 he advised:

"The admission forms indicate that '[the rest home/hospital] contracts with "the Doctors" who visit at least weekly.' It is not clear if 'the Doctors' provided emergency cover. It appears that [Dr E] had been the general practitioner of [Mr A] prior to his admission to [the rest home/hospital]. It may be significant to note, however, that [Dr E] had expressed to the management of [the rest home/hospital] 'that he did not wish to see residents in our rest home and hospital once admitted'. When medical care for [Mr A] was required urgently [Dr E] was requested to attend because no other general practitioner could be sourced. [Dr E] attended as a favour to [Ms D] and probably out of professional concern for his former patient, [Mr A]. On 23/6/06 a nurse had written that he

'will be medically admitted next week'. This planned first medical assessment would have been over one week after the date of admission.

It is my opinion that [Mr A] should never have been accepted by [the rest home/hospital] given his unstable clinical situation, without confidence that they could provide adequate medical services to him from a contracted GP. Adequate services would include emergency cover out of surgery hours. It is apparent that [the rest home/hospital] could not provide the medical care required and thus presumed upon the good will of [Dr E]. Having accepted [Mr A] as an in-patient, it is my opinion that it soon became apparent that he required urgent medical assessment for the urinary problems with which he was admitted, his confusion, and his falls. Given that medical attention could not be sourced by the rest home, and that his situation was deteriorating by the day, it is my opinion that it was the responsibility of the clinical nurse leader to provide both clinical direction to the nursing staff and leadership in making clinical management decisions. [Mr A] should have been transferred to hospital within the first three days of his admission to [the rest home/hospital] given his confusion, falls for which the cause was unknown, and urinary incontinence, in the absence of adequate medical review or ongoing medical supervision.

The apparent difficulty in sourcing care from 'the Doctors' other than at the time of a routine weekly visit also raises concern as to whether [the rest home/hospital] could provide adequate medical care to other residents of their institution.

It is my view that [Dr E] did not make notes at the time of his first visit on 26/6/06 as he did not perceive that visit to be a formal medical consultation. He wished to discuss his involvement in care for [Mr A] with the clinical nurse manager the next day. Thereafter he did keep good clinical records on 27/6/06 and 29/6/06 and undertook appropriate clinical assessments and laboratory investigations. By the time of this third visit on 29/6/06 he recognised the need for hospitalisation.

The expert nursing advisor has been critical of the length of time before [Mr A] was referred to secondary or tertiary care for assessment of his falls and deteriorating cognitive state. There was a seven day delay before [Dr E] was first involved in any assessment of [Mr A]. The responsibility for this delay rests, in my view, with the clinical nurse leader, [Ms D]. On the first day that [Dr E] assumed clinical responsibility, 27/6/06, he undertook an appropriate clinical assessment and ordered appropriate laboratory investigations. At the next review, 48 hours later, he made an appropriate decision to seek admission to hospital."