The Willows Rest Home Limited

Registered Nurse, RN E

Facility Manager, Ms D

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC00883)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2011, Mrs A (then aged 86 years) was admitted to a rest home from a public hospital. Mrs A had been treated for a scalp laceration following a fall.

2. The rest home is a facility that provides long-term hospital-level care, short-term respite care and palliative care. At the time of the events, staffing at the rest home included a facility manager, Ms D, who had overall responsibility for services; a clinical nurse manager, registered nurse RN E, who had responsibility for nursing care; six registered nurses; and enrolled nurses/healthcare assistants.

3. On admission, a care plan and nursing assessment were completed. The care plan did not record how to manage Mrs A's diabetes, dietary needs, prolapses, dementia and swallowing difficulties. Mrs A's care plan was not kept updated.

4. Mrs A had a number of changes to her condition, including a suspected mini stroke, a number of falls, swallowing difficulties and rapid weight loss. Mrs A's changing condition was not adequately monitored, assessed, managed or documented by rest home staff, and her personal care and hygiene were not maintained to an acceptable standard. Rest home staff also failed, on occasion, to complete incident forms or follow up incidents adequately.

5. A few months later, Mrs A was transferred to another rest home at the request of her daughters. After approximately a week, Mrs A was admitted to the public hospital. Investigations at hospital indicated that she was hypothermic, and had urosepsis[1] and acute renal failure secondary to infection. Mrs A died four days later.

Deputy Commissioner's findings

RN E

6. RN E breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[2] for providing suboptimal care to Mrs A with regard to care planning, incident reporting, and her monitoring, assessment, documentation and management of Mrs A's changing condition. RN E also breached Right 4(2) of the Code[3] for failing to comply with professional standards regarding documentation, and Right 3 of the Code[4] for leaving Mrs A for an unreasonable length of time soiled or wet from urine, which showed a lack of respect for her dignity.

Ms D

7. Ms D had overall responsibility for ensuring a quality service was provided to Mrs A. Ms D did not provide care to Mrs A with reasonable care and skill by failing to ensure that rest home staff completed incident forms and followed up incidents adequately.

[1] A urinary tract infection that has spread into the bloodstream.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[4] Right 3 of the Code states: "Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual."

Ms D also did not ensure that Mrs A's care plans were completed adequately and remained updated when her condition changed, and did not ensure that Mrs A's clinical record and documentation were kept up to date. For these reasons, Ms D breached Right 4(1) of the Code.

The Willows Rest Home Limited

8. The Willows Rest Home Limited breached Right 4(1) of the Code because it failed in its responsibility to ensure that staff complied with policies and provided services of an appropriate standard to Mrs A. The Willows Rest Home Limited breached Right 4(2) of the Code because its documentation was suboptimal. The Willows Rest Home Limited also breached Right 4(5) of the Code[5] for failing to ensure that its staff communicated effectively with one another and with other health professionals to ensure that Mrs A received quality and continuity of services.

9. Adverse comment is made about RN G for her contribution to the poor care provided to Mrs A.

Complaint and investigation

10. The Commissioner received a complaint from Ms B and Ms C about the services provided by a rest home to their mother, Mrs A. The following issues were identified for investigation:

- *Whether The Willows Rest Home Limited provided Mrs A with an appropriate standard of care between 20 Month1[6] and 18 Month4.*
- *Whether Registered Nurse RN E provided Mrs A with an appropriate standard of care between 20 Month1 and 18 Month4.*

11. On 14 March 2013, the investigation was extended to include the following issue:

- *Whether Ms D provided Mrs A with an appropriate standard of care between 20 Month1 and 18 Month4.*

12. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

13. The parties directly involved in the investigation were:

Mrs A (dec)	Consumer
Ms B	Complainant and consumer's daughter
Ms C	Complainant and consumer's daughter

[5] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."
[6] To ensure privacy, relevant months are referred to as Month1 – Month4.

Ms D	Facility Manager, the rest home
RN E	Clinical Nurse Manager, the rest home
Dr F	General practitioner
RN G	Registered nurse

14. Also mentioned in this report are registered nurses RN I, RN H and RN J, and Dr K.

15. Independent expert advice was obtained from a registered nurse, Margaret O'Connor (**Appendix A**).

Information gathered during investigation

Mrs A

16. On 8 Month1, Mrs A (then aged 86 years) was admitted to a public hospital, where she was treated for a scalp laceration as a result of a fall.

17. Mrs A's discharge summary records that she had a history of cognitive decline following a fall in 2007, with "4–6 weeks of increasing confusion and several minor falls", and a secondary diagnosis of "? Parkinson's disease". Her other medical conditions included type II diabetes, which was managed by diet. At the time of her discharge, Mrs A was assessed as requiring hospital-level care.

18. On 20 Month1, Mrs A was discharged from hospital and admitted to a rest home.

The rest home

19. The rest home is a facility owned and operated by The Willows Rest Home Limited. The rest home provides long-term hospital-level care, short-term respite care and palliative care.

Facility Manager — Ms D

20. Ms D, who is not a registered nurse, was employed as the Facility Manager at the rest home from the mid 1990s. As Facility Manager, Ms D is responsible for the day-to-day running of the facility. Ms D told HDC that she is "on the floor all day, every day" and that she does "pretty much everything".

21. Ms D stated that she is responsible for quality of care and ensuring that residents are safe and well cared for, and that her staff are well trained to deliver safe care in a timely manner. Ms D said that as she is not a nurse, the clinical care is delegated to the registered nursing staff.

22. The Facility Manager's job description described the purpose of the position as being "to effectively manage the Rest home as a quality continuing care environment, and viable business …". Other responsibilities of the Facility Manager detailed in the job description include:

a) ensuring the maintenance of safe, efficient and effective nursing practice;

b) planning and implementing ongoing care direction;

c) keeping all documentation up to date;

d) monitoring all accidents/incidents and ensuring accident forms are completed by staff and followed up;

e) ensuring the safe delivery and administration of all medications;

f) organising training and orientation for new staff; and

g) effectively managing and implementing a relevant continuing education programme for all staff.

23. Ms D said that she worked with RN E to do the care planning.

Clinical Nurse Manager — RN E

24. In 2011, the Clinical Nurse Manager at the rest home was RN E. She had been in this position for a number of years. Her appointment to a managerial position was approved by the Ministry of Health. Prior to training as a registered nurse, RN E had worked as a healthcare assistant at the rest home for five years.

25. The rest home employed RN E to work Monday to Friday from 7am to 4pm. When on duty, RN E was the registered nurse as well as the Clinical Nurse Manager. RN E described the key requirements of her role as to oversee all nursing care, manage the roster, and liaise with the Facility Manager.

26. In 2011, the rest home's Facility Manager's job description was identical to the job description for the Clinical Nurse Manager. The rest home advised HDC that the Facility Manager's and Clinical Nurse Manager's job descriptions were the same because many of their responsibilities overlap and they work very closely together.

Nursing staff

27. The rest home also employed six registered nurses plus enrolled nurses/healthcare assistants. The registered nurses were responsible for assessing, planning, and co-ordinating residents' care.

28. The purpose of the position as described in the registered nurse job description is "… the provision of quality nursing care to clients in accordance with the philosophy and objectives of [the rest home]".

29. Amongst other things, the rest home's registered nurse job description requires registered nurses to:

a) effectively implement the philosophy and objectives for residential and nursing care of the rest home in accordance with legislation and common law affecting nursing practice;

b) maintain accurate and legally appropriate documentation of nursing care;

c) maintain open and effective communication channels with staff, members of the health team, residents and their relatives;

d) maintain effective working knowledge of the rest home's policies and procedures; and

e) contribute to the provision of quality nursing care to clients by the assessment of health status, preparation and monitoring of care plans and provision of clinical services in accordance with contemporary practice.

Initial assessment and care planning

30. On 20 Month1, Mrs A was admitted to the rest home. She was accompanied by one of her daughters, Ms B.

31. Ms B told HDC that RN G gave her Mrs A's Care Plan[7] to fill in. Ms B completed some of the forms and gave them back to RN G. Ms B said that she did not complete all of the admission forms, as she thought that some of the forms were for the staff to fill out. Ms B also provided the rest home with a specific meal regimen. RN E agrees that Ms B did complete some parts of the Care Plan and filled in a menu but did not complete all the forms. The Care Plan was signed by RN E.

32. The rest home's Resident Nutrition and Hydration Policy states that a special diet must be recorded in the client's Care Plan. There is no record of Mrs A's diet in her Care Plan, or that she was diabetic.

33. That same day, RN E completed a Nursing Assessment. RN E recorded that Mrs A was a moderate risk for falls, became very frothy in the mouth, and had slurred speech at times. The Nursing Assessment also records that she suffered from pain in her back and legs from osteoarthritis.[8] A Pressure Risk Assessment was completed and records that she was "at risk".

34. RN E also completed a further separate Falls Risk Assessment, on which she recorded that Mrs A was a high risk for falls.

35. The progress notes from admission document that Mrs A was slightly confused but was well and settled. RN G recorded Mrs A's baseline observations at 2.15pm.[9] Her respiration rate is recorded as 24 breaths per minute (BPM), blood pressure 120/78mmHg, and weight 62kg.[10] Her pulse is recorded as 132 beats per minute (bpm).[11] Despite her high pulse rate, there is no record of Mrs A's pulse being

[7] The document titled "Care Plan" is dated 26 Month1, but the last page is dated 20 Month1. At the bottom of the last page, RN E signed the Care Plan and recorded the date as 20 Month1. The Care Plan is four pages long and details Mrs A's problems, goals and staff interventions.
[8] Degenerative joint disease.
[9] Mrs A's temperature and oxygen saturation were not recorded.
[10] Normal measurements for the average healthy adult are: blood pressure 110–130/70–90mmHg; pulse 60–80bpm at rest; respirations 12–18BPM; temperature 36.3–37.3°C. For the elderly, the normal measurement for temperature is usually slightly lower: 35.8–37.3°C.
[11] A pulse rate of more than 100bpm is known as tachycardia. In some cases, tachycardia may cause no symptoms or complications. However, tachycardia can seriously disrupt normal heart function, increase the risk of stroke, or cause sudden cardiac arrest or death.

assessed or monitored further. Her general practitioner (GP) was not informed of her high pulse.

36. On 21 Month1, the rest home's GP, Dr F, assessed Mrs A. Dr F told HDC that it is his usual practice to see new clients within three days of their admission to the rest home. As part of his assessment, he ordered a blood test and mid-stream urine test (MSU). He recorded that Mrs A weighed 62.4kg, her blood pressure was 120/70mmHg, and that she was severely demented.

37. On 26 Month1, RN E completed an Initial Nursing Care Plan.[12] She recorded information about Mrs A's mobility, communication, grooming, eating and drinking, skin, independence, pain and continence. In relation to eating and drinking, RN E noted that there were times when Mrs A would refuse to eat and would spit out her food. It is also noted that she held spit/sputum[13] in her mouth if she did not have tissues to spit into.

38. With regard to continence, RN E noted in Mrs A's Initial Nursing Care Plan that Mrs A was prone to constipation and incontinence if she was not toileted regularly. In addition, RN E recorded that Mrs A was prone to diarrhoea because she had a rectal prolapse and took laxatives.

39. There was some confusion as to whether Mrs A had a rectal or vaginal prolapse. Mrs A's family told HDC that she had a vaginal prolapse. In contrast, the rest home told HDC that she had a rectal prolapse. Dr F advised HDC that Mrs A had a vaginal prolapse kept in place with a pessary,[14] and a rectal prolapse that was managed by the rest home as part of her bowel management.

40. The rest home's policy on care plans states: "The registered nurse is responsible and accountable for directing the care of residents ensuring that the plan and care as developed is followed." The policy requires progress notes to be updated with any changes to the care plan. The policy also requires each care plan to be evaluated, reviewed, and amended either when clinically indicated by a change in the resident's condition or at least every six months, whichever comes first.

41. Mrs A's Care Plan was not updated during her three-month stay at the rest home. However, a "Daily Care Review" chart, which recorded Mrs A's hygiene, bowel motions, urine output, diet, fluid intake, and behaviour, was completed.

Ongoing assessment and monitoring

20 Month1–11 Month2

42. From 20-24 Month1, it appears from the progress notes that Mrs A settled well and there were no concerns.

[12] The Initial Nursing Care Plan is a one-page document listing Mrs A's needs, goals and interventions.
[13] A mixture of saliva and mucous coughed up from the respiratory tract.
[14] A medical device used to hold the prolapse in place.

43. On 24 Month1, a healthcare assistant recorded that she treated Mrs A's rectal prolapse with a cold compress. On 26 Month1, it is recorded that the prolapse was "pushed back in by [RN G]". Similar notes were also made on 2 and 11 Month2.

44. On 27 Month1, it is recorded in the progress notes that Mrs A was tearful and short of breath. Her oxygen saturation was 99% and her pulse was 81bpm. Mrs A was assessed by the registered nurse on duty, who noted that Mrs A was asymptomatic and that no oxygen was required. On 29 Month1, Dr F reviewed Mrs A and recorded that she was stable.

45. There are no concerns recorded in the progress notes from 1-3 Month2. There are no progress notes from 4-9 Month2.

First fall, 11 Month2

46. The rest home's Falls Policy states: "All falls are reported and investigated ensuring that appropriate assessments are completed and management plans put in place."

47. On 11 Month2, at 4.20pm, Mrs A fell while trying to stand up. The fall was witnessed by RN G. RN G recorded that Mrs A's observations were stable and no abnormalities were detected, but did not record her observations.

48. RN G and RN I completed an incident report. Dr F was not asked to review Mrs A. The incident report records: "Daughter informed while at the facility", which is consistent with the progress notes entry: "Daughter informed". The rest home told HDC that Mrs A's family were informed about the incident at 5pm. In contrast, Ms C, one of Mrs A's daughters, told HDC that she was not told about this fall.

49. RN E told HDC that Mrs A was observed for a period of 24 hours after the fall. It is recorded in Mrs A's progress notes for that day that she was "monitored @ night". RN E said that, in hindsight, Mrs A's observations should have been taken again after the fall but were not.

12–22 Month2

50. There are no progress notes for 12 Month2.

51. On 13 Month2, Dr F reviewed Mrs A and no changes were reported.

52. There are no progress notes for 14–19 Month2 or 21–22 Month2.

TIA,[15] *23 Month2*

53. On 23 Month2, the progress notes record that Mrs A was sleeping throughout the morning but was able to be roused when her name was called. RN E stated that she took Mrs A's temperature, pulse, oxygen saturation and blood pressure at 10.30am. RN E queried whether Mrs A had suffered a TIA. She then called Dr F and reported

[15] Transient Ischaemic Attack (TIA) is a transient episode of neurological dysfunction caused by loss of blood flow to the brain. TIA is also known as a mini stroke.

Mrs A's observations.[16] Dr F told HDC that from what had been described by RN E, he thought that Mrs A was not acutely unwell, but told RN E that he would go to the rest home to review her.

54. Mrs A's family were not informed of the change in Mrs A's condition until 4.30pm when Ms C arrived at the rest home to visit her mother. The rest home told HDC that RN E apologised to Ms C for the oversight and for not informing her sooner.

55. Due to surgery commitments, Dr F was not able to review Mrs A until 8.30pm. The time of the visit was recorded in his GP notes and in Mrs A's progress notes. In contrast, Ms C told HDC that she was with her mother until 10.30pm, and that Dr F would have assessed her sometime after that.

56. Dr F stated that Mrs A was asleep when he arrived, and would not open her eyes for him. He recorded in Mrs A's progress notes that she seemed comfortable, but was mildly dehydrated. He queried whether Mrs A had experienced a TIA. In his notes under "action", Dr F documented "wait and see". Dr F asked the nursing staff to look after Mrs A in bed with all cares, and said that he would review her in two or three days' time. Dr F told HDC that there is little else that can be done in response to a TIA. Although he would sometimes suggest aspirin, he did not feel this was safe for Mrs A because of her head injuries suffered prior to admission.

57. RN G told HDC that she phoned Ms C while Dr F was still at the rest home so that he could speak to her about Mrs A's review. RN G did not manage to contact Ms C, and noted in the progress notes that she was not able to leave a message as there was no voicemail. RN H recorded in the progress notes that she updated Ms C the following morning when she came in to visit her mother.

58. Mrs A's observations were taken at 10pm[17] and again at 12.30am[18] the following morning. At 10pm her temperature and pulse were both below average. Her respiration rate was not recorded. By 12.30am, her temperature had risen to just below average, her pulse was still low, and her respiration rate was again not recorded.

59. The rest home's Resident Nutrition and Hydration Policy states: "[I]f there is a problem with fluid intake a fluid balance chart will be introduced." The rest home told HDC that staff encouraged Mrs A to drink fluids. However, following Mrs A's suspected TIA and Dr F's observation that she was mildly dehydrated, a fluid chart was not started.

Second fall, 24 Month2

60. On 24 Month2, Mrs A had an unwitnessed fall. It is recorded in the progress notes that a nurse aide found Mrs A on the floor at 4.20pm, and that she was put into bed with the bed rails up. Dr F was not called to review her. Mrs A was recorded as

[16] Temperature 36.2°C, pulse 84bpm, blood pressure 140/98mmHg, respirations 22BPM, and oxygen saturation 96%.
[17] Temperature 34.6°C, pulse 52bpm, blood pressure 140/90mmHg, and oxygen saturation 90%.
[18] Temperature 35.7°C, pulse 50bpm, blood pressure 140/93mmHg, and oxygen saturation 99%.

having slurred speech and being quite restless. An incident form was completed but does not record whether the family was informed.

25–26 Month2

61. On 25 Month2, no concerns were reported but RN G recorded in the progress notes that Mrs A was sleeping on and off during the day. A urine dipstick test[19] was performed. Mrs A's temperature, blood pressure, respiration rate and pulse were also recorded on a multi-purpose chart.[20] Her temperature was slightly below average.

62. On 26 Month2, Dr F reviewed Mrs A and recorded in the progress notes that she "seem[ed] better, brighter, more alert". In his GP notes he recorded: "Check renal function, MSU."[21] Dr F placed a request for a full blood count, renal function check, and an MSU into the laboratory folder at the rest home. Laboratory staff visit the rest home weekly to undertake any testing that is required. Dr F told HDC that it is the laboratory's responsibility to ensure that the tests are conducted. RN E told HDC that the nursing staff had difficulty obtaining a urine sample from Mrs A. RN E acknowledged that the nursing staff should have kept trying. On 8 Month3, the laboratory sent Dr F a message to say that the test had not been completed. Dr F acknowledged that he should have followed up with the rest home as to why the MSU had not been completed.

63. A diet profile was also completed for Mrs A on 26 Month2, recording that she needed a soft, puréed diet. It is unclear who completed the diet profile.

64. Ms C told HDC that she does not think her mother's diet was followed, as she often found her with chicken on the bone, or whole pieces of steak. Ms C also stated that Mrs A was never given fruit. Ms B also said that she saw her mother with sugar, cakes and cream on a number of occasions. RN E told HDC that she does not think this is correct, as the rest home does not usually have chicken on the bone or whole pieces of steak. RN E also said that Mrs A had fresh fruit every day.

65. Ms C further complained that Mrs A was not given enough fluid, and did not have access to water when she needed it. RN E told HDC that Mrs A tolerated fluids well, was given them regularly, and also had drinks available to her in her fridge. RN E acknowledged that Mrs A's fluid intake was not recorded.

27 Month2–15 Month3

66. There are no progress notes for 27 Month2.

67. On 28 Month2, Mrs A was observed to be eating little, but was drinking. RN J documented that Mrs A was uncomfortable and had a tender abdomen. Mrs A's

[19] A basic diagnostic tool used to determine pathological changes in a patient's urine. The results of the dipstick test showed a trace of protein and glucose.
[20] Temperature 35.7°C, blood pressure 130/88mmHg, respirations 20BPM, and pulse 60bpm.
[21] Mid-stream urine test.

bowels had not opened, so RN J gave her an enema.[22] Mrs A's blood pressure, pulse and weight were recorded on a blood pressure record sheet.[23]

68. It is recorded in the progress notes on 29 Month2 that Mrs A had a loose bowel motion and that her abdomen was very soft. There are no progress notes for 30 Month2.

69. On 31 Month2, Mrs A complained of backache, and a pain chart was commenced. There is no place for staff to sign the chart, and it is not cross-referenced in the progress notes. Panadol was administered to manage Mrs A's backache, and the pain chart was completed until 6 Month3.

70. On 3 Month3, Dr F reviewed Mrs A and noted that she was still very demented. He explained that the reason he recorded this was that he thought she had dementia but had not really improved since her admission.

71. On 8 Month3, Dr F received the results of the blood tests he had ordered on 26 Month2. Mrs A's results showed decreased haemoglobin and an increase in neutrophil count.[24] RN G wrote in Mrs A's progress notes: "Bloods Taken — urine spec[imen] to be collected."

72. On 11 Month3, Dr F reviewed Mrs A and noted that she was "stable with no deterioration".

73. On 14 Month3, a urine dipstick test was done. Mrs A's blood pressure and pulse were also recorded on a multi-purpose chart.[25]

74. There are no progress notes for 4, 6–7, 9, 11–13 or 17 Month3.

Third fall, 18 Month3

75. On 18 Month3, Mrs A fell again. RN J recorded the fall in the progress notes. No injury was reported. An incident report was not filled out, and the family was not contacted. Mrs A's blood pressure, pulse and weight were recorded on a blood pressure record sheet.[26]

76. There are no progress notes for 19, 21, 23, 25–26, or 29 Month3 and 2, or 4–7 Month4.

Weight loss

77. Mrs A's weight on admission is recorded as 62kg. On 28 Month2, Mrs A is recorded as still weighing 62kg. However, by 18 Month3, Mrs A was recorded as weighing 58kg.

[22] The introduction of liquid into the rectum to evacuate the bowels.
[23] Blood pressure 120/80mmHg, pulse 81bpm and weight 62kgs.
[24] The measure of neutrophils (a type of white blood cell that fights against infection) present in the blood.
[25] The dipstick result showed traces of leukocytes (white blood cells) and protein. Blood pressure 130/80mmHg and pulse 68bpm.
[26] Blood pressure 120/70mmHg, pulse 95bpm and weight 58.6kg.

78. On 27 Month3, it is recorded in the progress notes that Mrs A was eating very little. Ms C told HDC that she did not think Mrs A was being fed enough, and that RN G told her that it did not matter if Mrs A did not eat, so long as she had fluids. RN G told HDC:

> "In the evening (tea time), [Mrs A] was not very interested in food. I would have mentioned to [Ms C] that I always checked that a good meal had been eaten at lunch time. Therefore, I did not push the evening meal but always made sure she had plenty of fluids."

79. Ms C also told HDC that she saw RN G "shovel[l]ing food down [Mrs A's] throat".

80. The rest home's policy titled "Assisting residents to eat" states that when a resident suddenly starts to lose weight, the reasons for the weight loss should be investigated. It also states: "Nutritional support is provided for our residents who are malnourished and who are unable to maintain body weight with a normal balanced diet ..." In addition, the rest home's Resident Nutrition and Hydration Policy states: "If the resident has problems swallowing, fluids will be thickened."

81. RN E told HDC that Mrs A was started on Sustagen[27] "probably mid-[Month4]" but that this was not recorded in her Care Plan or progress notes.

82. A dietitian or speech language therapist was not consulted to assess the reasons for Mrs A's weight loss and whether swallowing difficulties could be the cause. RN E told HDC that she did not feel that Mrs A needed a referral to a language therapist or dietitian, as her problem was with phlegm in her mouth. RN E acknowledged that, in hindsight, she should have referred Mrs A to a dietitian.

8 Month4–16 Month4

83. On 8 Month4, Dr F was asked to review Mrs A as she was reported to be having a problem with excessive saliva and sticky mucous in her mouth. Dr F also recorded that Mrs A was constipated and her weight was 58kg. He anticipated that if her issues with swallowing improved, this would remedy "the weight situation".

84. Dr F recorded in the progress notes that Mrs A had oral thrush, and prescribed Daktarin gel to be taken four times per day for one week.[28] The administration record shows that a number of doses of Daktarin gel were missed or not recorded.[29]

85. Dr F did not order an MSU, as he assumed Mrs A's urine was being tested regularly by dipstick at the rest home. He ordered blood tests, which showed a mild elevation of white blood cells (15.98b/L), normal haemoglobin (115g/L) and reduced creatinine (98 down from 128µmol/L). Dr F told HDC that he thought this was consistent with mild dehydration, and did not consider it a dramatic change in her renal function. He

[27] A nutritional supplement.
[28] Daktarin oral gel is an antifungal medicine used to treat fungi and yeast infections.
[29] Two doses were missed or not recorded on 12 Month4, one dose on 14 Month4, three doses on 15 Month4, one dose on 17 Month4, and one dose on 18 Month4.

is unsure whether he communicated to the rest home's nursing staff that Mrs A was mildly dehydrated.

86. A fluid chart showing intake and output was not started. RN E told HDC that Mrs A was given fluids but that that was not recorded.

87. Ms C advised HDC that she told Dr F on 8 Month4 that her mother was suffering from back pain. Dr F does not recall discussing this with Ms C. However, Dr F and RN E recall discussing Mrs A's back pain with each other. Dr F told HDC that Mrs A's pain was likely to be a combination of osteoporosis[30] and osteoarthritis, and he did not believe it was a significant issue. Dr F said that back pain is common, and simple pain relief was available. He told HDC that he was not aware of Mrs A having ongoing problems with back pain.

88. Mrs A's bowel movements were recorded on her daily care chart. The rest home provided Mrs A's bowel records for 13 Month3 to 17 Month4, which showed that her bowels moved regularly. There is no mention in Mrs A's progress notes that she was constipated. However, Dr F recorded on 8 Month4 that Mrs A was "constipated still". Dr F recommended Movicol[31] and Laxsol[32] twice daily as required from 11 Month4. In the rest home's response to HDC, it confirmed that Mrs A did suffer from constipation, and that Laxsol, Movicol and fruit were given. However, it is not recorded in the progress notes if or when these were given.

89. There are no progress notes for 9 Month4. On 10 Month4, RN H recorded in the progress notes that Mrs A had pain, but did not record where she was suffering the pain. RN H gave Mrs A Panadol and recorded that it was effective.

90. There are no progress notes for 11 Month4. On 12 Month4, RN G documented Mrs A's temperature as 94.2°F (34.6°C).[33] RN E told HDC that such a low temperature recording should have been investigated by the registered nurse and the temperature retaken, and that the thermometer should have been checked as to why the temperature was recorded in Fahrenheit. Despite this low temperature recording, Mrs A's temperature was not retaken, and her temperature was not reported to Dr F.

91. Over the next two days, Mrs A continued to have problems with sputum, swallowing difficulties, and loose bowel motions, and she was eating poorly. From 14 Month4, RN E kept a record of Mrs A's incontinence, and this was completed daily until Mrs A left the rest home on 18 Month4.

92. On 15 Month4, Mrs A was seen by Dr F, who recorded that she seemed to have problems swallowing but was eating and drinking well. He also noted that Mrs A was afebrile, her frothy sputum continued, and her chest and abdomen were clear. Dr F told HDC: "[M]y impression was that she was not particularly unwell clinically and I thought she was in fact a little better." Dr F ordered repeat blood tests.

[30] Progressive bone disease.
[31] A laxative.
[32] A laxative.
[33] The normal temperature range for an average healthy adult is 36.3–37.3°C.

93. On 16 Month4, Mrs A weighed 58.6 kg.

Complaint to the rest home

94. On 15 Month4, Ms C submitted a written complaint to the rest home about her concerns over the care provided to her mother, in particular, the number of times she found her mother drenched in urine or soiled.

95. In her response to HDC, RN E stated:

> "I do realize that some days the staff may not get to [Mrs A] in time to take her to the toilet and accidents happen but I can say that it's not all the time. There are times that [Mrs A] can be toileted and half an hour later you come back to find her soiled or wet. I am not trying to make excuses, we did have a staff meeting upon receiving the complaint and the staff was made aware of where we were lacking in the care provided for [Mrs A]."

96. RN E told HDC that Mrs A ended up sitting in urine or faeces because there was a breakdown in communication between staff working different shifts.

97. Ms C said that she found Mrs A without socks on her feet (it was winter) and often found her fully clothed in her bed. Ms C also complained about the deterioration in Mrs A's mobility and her significant weight loss. RN E told HDC that Mrs A would get up and mobilise herself regularly but that in the evenings she was transported back to her room by wheelchair, as her back was often too sore for her to walk back to her room.

98. The rest home replied to Ms C's complaint by email on 21 Month4, apologising to her and informing her that a new toilet and exercise regimen had been implemented for Mrs A after they received the complaint. Ms D stated:

> "I was upset to receive my 3rd complaint in that time [37 years]. I consider myself to be personally responsible. I wish to extend my sincere apology to you [Ms C] for causing you this anguish and to [Mrs A] for letting her down so badly …
>
> I have had two staff meetings with both morning and afternoon staff who also wish to apologise for their part in letting both you and [Mrs A] down as well.
>
> I have put into place strategies w[h]ere we are all responsible for checking on residents care and checking on each other, to ensure that nothing like this happens again …"

Subsequent events

99. On 18 Month4, Mrs A was transferred to a different rest home at the request of her daughters. Ms C stated:

> "The new [rest home] [was] very attentive, but believed she was depressed because of the crying sounds. Mum wasn't [there] long, when they phoned me and asked if they could send her to hospital, as something didn't seem right …"

100. On 24 Month4, Mrs A was admitted to hospital. Investigations indicated that she was hypothermic and had urosepsis[34] and acute renal failure secondary to infection.[35]

101. HDC requested further information from the DHB. Dr K, Clinical Head — Emergency Care, provided the following comment:

> ["Mrs A] presented on 25 [Month4] with a history of deterioration over the past week, disorientation reduced oral intake over the last three days prior to presentation …
>
> On arrival [Mrs A] was extremely unwell with septic shock and was treated with IV antibiotics after investigations to find the source. The investigations indicated that she had urosepsis with a urine test …
>
> It would be difficult to say how long the patient had the UTI prior to presentation in the emergency department. History of the presenting complaint may give us some idea of the duration of symptoms, however, this patient had dementia and thus loss of short term memory and [did not speak English] as a first language which would make the history difficult."

102. Mrs A died four days later.

Changes made

103. Ms D and RN E advised HDC of the following changes at the rest home since and/or in response to these events:

a) Separate job descriptions for the Clinical Nurse Manager and the Facility Manager have been created, which show the differences in delegated roles.

b) A registered nurse communication book has been implemented for communication between staff on different shifts. This book is audited by the Facility Manager.

c) After reviewing a resident, the GP now writes notes in the doctor's communication book as well as in the doctor's own record. Prior to the complaint, this book was written in by the nursing staff to communicate to the GP which resident(s) the doctor needed to see.

d) A registered nurse accompanies the GP during his or her review of residents.

e) Care plan audits are completed monthly.

f) The rest home's complaint form has been amended to record whether or not the complainant is satisfied with the outcome.

g) The incident form has been amended to state that vital signs need to be taken. Incident forms relating to falls are now faxed to the GP so that he or she is aware of the resident's fall.

[34] A urinary tract infection that has spread into the bloodstream.
[35] Mrs A's observations were: blood pressure 84/43mmHg, pulse 110bpm and oxygen saturation 90%.

h) A protocol book was created and includes all of the rest home's policies so they can be accessed easily by the nursing staff.

i) The nursing staff have been reminded to complete short-term care plans after any incident.

j) RN E spoke to the nursing staff about the importance of documentation, taking residents' observations and reporting any abnormalities.

Responses to provisional opinion

104. Responses to the provisional opinion were received from Ms D, on behalf of herself and the rest home, RN E, and RN G.

The rest home/Ms D

105. Ms D advised that the rest home has made the following additional changes:

a) The admission form now includes space for a family to say when they would like to be contacted and at what times.

b) A resident's family newsletter has been introduced. The autumn 2014 edition outlines the rest home's complaints process.

c) Bristol Stool charts have been introduced for each resident.

d) A new fluid and food intake chart has been developed and introduced.

e) The incident form has been further updated to include space to record the action plan and evaluation.

f) Observations guidelines have been developed.

g) All registered nurses have been provided with copies of the rest home's guidelines, which also form part of its internal training.

h) All staff have had external training on documentation.

106. The rest home provided HDC with a copy of its monthly in-service training programme.

107. Ms D told HDC that she takes "responsibility for the lack of documentation and follow-up affecting [Mrs A's] care". She is disappointed and angry at herself for letting Mrs A and her family down. Ms D stated: "I have taken all of this on board and am making changes. I love doing this and have always enjoyed the residents. It is my aim to do much better, so that this never happens again for the sake of my residents and their families."

108. Since these events Ms D has undergone further training in management and care, details of which have been provided to HDC.

RN E

109. RN E told HDC: "It has always been my passion to be a Registered Nurse and provide optimum care for people, that is why I am so bitterly disappointed and angry with myself for falling short in this instance."

110. RN E advised that she was also involved in a number of the changes (referred to above) that have been implemented by the rest home. RN E also advised that a notice has been placed on the residents' notice board to explain to families that they should inform the rest home if they would like to see a doctor about their family member. RN E provided HDC with information about a number of nursing and management courses she has attended since these events.

RN G

111. RN G told HDC that she regrets that her documentation was lacking at this time. She stated: "I would have passed the information on verbally, I realize that with hindsight that I must document not just pass on verbally." RN G stated that since this incident, she has made documentation her priority, and she now carries a notebook and pen with her at all times. She said further that it was never her intention to cause Mrs A's family this upset.

Relevant standards

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

> "… **Independence, Person Privacy, Dignity, and Respect**
>
> **Standard 1.3** Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.
>
> …
>
> **Service Management**
>
> **Standard 2.2** The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> …
>
> **Quality and Risk Management Systems** …
>
> **Standard 2.3** The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

Criteria The criteria required to achieve this outcome include the organisation ensuring:

2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

…

2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

…

Adverse event reporting

Standard 2.4 All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

…

Family/whānau participation

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

…

Consumer information management systems

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

… **Service Delivery/Interventions**

Standard 3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

…

Evaluation

Standard 3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

…

Nutrition, Safe Food, and Fluid Management

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

113. The Nursing Council of New Zealand Competencies for registered nurses scope of practice provide:[36]

Domain one: professional responsibility

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

Domain two: management of nursing care

- Competency 2.1: Provides planned nursing care to achieve identified outcomes.

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

Competencies for nurses involved in management

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

Domain four: interprofessional health care & quality improvement

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

Opinion: RN E

114. RN E was employed by the rest home to work Monday to Friday, 7am to 4pm. When RN E was on duty, she was both the Clinical Nurse Manager and registered nurse.

115. The standard expected of a registered nurse in management is to promote a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.[37] RN E described her role as Clinical Nurse Manager as to oversee all nursing care, manage the roster, and liaise with the Facility Manager. According to her job description, her responsibilities also included planning and implementing ongoing care direction, keeping all documentation up to date, and monitoring all accidents/incidents.

116. In her role as a registered nurse, RN E also had responsibility for care planning, documentation of nursing care, communication with staff and residents' families, and compliance with the rest home's policies and procedures. A registered nurse must also

[36] This document was first published by the Nursing Council of New Zealand (NCNZ) in December 2007 (available at www.nursingcouncil.org.nz).
[37] NCNZ, "Competencies for registered nurse scope of practice" (December 2007), Competencies for nurses involved in management.

demonstrate accountability for directing, monitoring, and evaluating nursing care that is provided by enrolled nurses and others.[38]

Initial assessment and care planning — Breach

117. In order to provide good care in a rest home environment, residents' care plans must be well documented. A care plan is a fundamental tool that helps enable all staff to provide care that is appropriate and consistent with a resident's needs. It is a tool that informs staff of a resident's changing needs and where the care provided needs to be modified. It is the proper documentation of this process that ensures continuity of care. RN E did not complete Mrs A's Care Plan and Initial Nursing Care Plan adequately to reflect her health issues, and these plans were not updated following her health changes. The deficiencies in Mrs A's care plans affected the ability of the rest home's staff to provide appropriate care.

118. The rest home's policy on care plans states that "[t]he RN is responsible and accountable for directing the care of residents ensuring that the plan and care as developed is followed". Furthermore, as Clinical Nurse Manager, RN E had overall responsibility for care planning.

119. In accordance with the rest home's policy on care plans, on 20 Month1, the day of Mrs A's admission, the Care Plan was completed and signed by RN E, with input from Mrs A's family. That same day, RN E completed a Nursing Assessment and recorded that Mrs A was a moderate risk for falls, became very frothy in the mouth, and had slurred speech at times. RN E also completed a further separate falls risk assessment and recorded that Mrs A was a high risk for falls.

120. On 21 Month1, the rest home's GP, Dr F, assessed Mrs A and recorded that she was severely demented. RN E did not record in the care planning documentation that Mrs A had dementia.

121. On 26 Month1, RN E completed an Initial Nursing Care Plan. She recorded information about Mrs A's mobility, communication, grooming, eating and drinking, skin, independence, pain and continence. In relation to eating and drinking, RN E noted that there were times when Mrs A would refuse to eat and would spit out her food. RN E also recorded that Mrs A held spit/sputum in her mouth if she did not have tissues to spit into.

122. With regard to continence, RN E noted that Mrs A was prone to constipation and incontinence if she was not toileted regularly. In addition, RN E noted that Mrs A was prone to diarrhoea because she had a rectal prolapse and took laxatives. The care planning documentation did not provide details for the management of Mrs A's bowels or her rectal and vaginal prolapses. My expert nursing advisor, Ms Margaret O'Connor, noted: "Discussion with [Mrs A's] GP on management of the prolapse and care planning of his recommendations would have been appropriate."

[38] NCNZ, "Competencies for registered nurse scope of practice" (December 2007), Competency 1.3.

123. Mrs A had type II diabetes. However, there is no reference in Mrs A's Care Plan to her diabetes or how this should be managed. Ms O'Connor observed that there was no care plan for monitoring Mrs A's diabetic status. She advised that it is prudent to monitor this at a facility level, particularly at admission for a baseline, and randomly afterwards, particularly if there are health status changes.

124. The rest home's policy on care plans required progress notes to be updated with any changes to the care plan. The policy also required each care plan to be evaluated, reviewed, and amended either when clinically indicated by a change in the resident's condition or at least every six months, whichever came first.

125. Mrs A had a number of changes to her condition, including a suspected TIA on 23 Month2, three falls between Month2 and Month3, swallowing difficulties and rapid weight loss. Although a daily care review chart was completed, which recorded Mrs A's hygiene, bowel motions, urine output, diet, fluid intake, and behaviour, RN E did not update Mrs A's Care Plan following any of these identified changes to her condition.

126. Ms O'Connor considered that Mrs A's Care Plan was deficient in several areas, including management of her diabetes, dietary needs, prolapses, dementia and swallowing difficulties.

127. By failing to ensure Mrs A's care plans were completed adequately, particularly in relation to the management of her various health issues, and were updated when Mrs A's condition changed, RN E did not provide care to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Clinical oversight and lack of interventions — Breach

128. As Clinical Nurse Manager and a registered nurse, RN E was required to ensure that appropriate standards of clinical practice were implemented, and to promote an environment that supported nurses' abilities to provide safe, effective and ethical nursing practice. The important role of a Clinical Nurse Manager in providing leadership and oversight to staff in a rest home environment has been the subject of previous HDC reports.[39]

129. Ms O'Connor stated: "The nursing staff and particularly RN E have responsibility to instigate further assessment and interventions as appropriate." Ms O'Connor also stated that there were occasions where the nursing staff did not respond adequately to Mrs A's changing needs by failing to implement relevant interventions.

130. I note the following occasions where further assessment and interventions should have been carried out. On 24 Month2, the day after Mrs A's suspected TIA, she had an unwitnessed fall. Dr F was not called to review Mrs A despite RN E noting in her records that she had slurred speech and was quite restless.

[39] See Opinions 11HDC000528 and 09HDC01974 (available at www.hdc.org.nz).

131. On 26 Month2, Dr F reviewed Mrs A and requested an MSU. RN E told HDC that the nursing staff had difficulty obtaining a urine sample from Mrs A. RN E acknowledged that the nursing staff should have kept trying. The MSU was not completed.

132. On 28 Month2, Mrs A weighed 62kg (her admission weight) but was observed to be eating little. Three weeks later, on 18 Month3, Mrs A weighed 58kg. The rest home's "Assisting residents to eat" policy states that when a resident suddenly starts to lose weight, the reasons for the weight loss should be investigated and nutritional support is to be provided to residents who cannot maintain their body weight. RN E told HDC that Mrs A was started on Sustagen around mid-Month4. However, there is no record of the provision of Sustagen or any other supplement in Mrs A's care plan or progress notes.

133. A dietitian or speech language therapist was not consulted to assess the reasons for Mrs A's weight loss and whether swallowing difficulties could be the cause. RN E told HDC that she did not feel that Mrs A needed a referral to a language therapist or dietitian, as her problem was with phlegm in her mouth. RN E acknowledges that, in hindsight, she should have referred Mrs A to a dietitian.

134. I am critical that Mrs A's notes do not provide a clear indication of her food intake. Given Mrs A's rapid weight loss, further multidisciplinary input should have been sought. Ms O'Connor noted: "Suitable interventions would have [been] the introduction of a food chart to identify intake, weekly weighs, supplementation and referral to the GP and/or Dietician." Ms O'Connor considered that Mrs A's weight loss and dietary requirements were not appropriately managed.

135. The rest home's Resident Nutrition and Hydration Policy states: "If there is a problem with fluid intake, a fluid balance chart will be introduced." On 23 Month2 and 8 Month4, Dr F recorded in his notes that he thought Mrs A was mildly dehydrated. Following Dr F's reviews, fluid charts were not started. However, the rest home and RN E told HDC that fluids were encouraged but not recorded. I am critical that there is no record of Mrs A's fluid intake.

136. I also note that the rest home's Resident Nutrition and Hydration Policy requires fluids to be thickened where a resident has swallowing difficulties. On two occasions in Month4, Dr F recorded that Mrs A had issues swallowing. However, Mrs A was not given thickened fluids.

137. RN E failed to recognise when further assessments or referrals should be made. As RN E had clinical oversight of Mrs A's care, she should have ensured that appropriate steps were taken to manage Mrs A's nutrition, hydration and change in condition. Furthermore, Dr F should have been advised of these changes.

138. For the reasons given above, I find that RN E did not ensure that Mrs A's changing needs were adequately monitored, assessed, documented or managed. In addition, the failure by a number of registered nurses to monitor and assess Mrs A appropriately, and document adequately, demonstrates a lack of clinical leadership or oversight by

RN E. As a result, I consider that RN E did not provide care to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Incident reporting — Breach

139. According to her job description, RN E was responsible for monitoring all accidents and incidents and ensuring accident and incident forms were completed by staff and followed up.

140. Mrs A was assessed at her admission as being a high risk for falls. On 11 Month2, at 4.20pm, Mrs A fell while trying to stand up. RN G and RN I completed an incident report. RN G noted on the incident report form that Mrs A's observations were stable, but did not record her observations.

141. Following this fall, Dr F was not asked to review Mrs A. RN E told HDC that Mrs A was observed for a period of 24 hours after the fall. It is recorded in Mrs A's progress notes for that day that she was "monitored @ night". RN E told HDC that, in hindsight, Mrs A's observations should have been taken again after the fall, but were not.

142. On 24 Month2, Mrs A had an unwitnessed fall. Dr F was not called to review her. Mrs A was recorded as having slurred speech and being quite restless. RN G completed an incident report form. She did not record whether Mrs A's family was informed, although it is recorded in the progress notes that Mrs A's daughter came in to visit.

143. On 18 Month3, Mrs A fell. RN J recorded the fall in the progress notes but did not complete an incident report. Mrs A's family was not contacted.

144. I consider that by failing to ensure that the rest home staff completed incident forms and followed up adequately, RN E did not provide care to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Documentation — Breach

145. As a registered nurse, RN E was required to maintain clear, concise, timely, accurate, and current records.[40] In addition, as Clinical Nurse Manager, RN E's job description also required her to ensure that the rest home's documentation was up to date.

146. Mrs A's progress notes were often not completed. Ms O'Connor commented: "[T]he documentation in this case [is] so poor it has been difficult to build a clinical picture of [Mrs A's] needs during her time at [the rest home]." I agree.

147. There are no progress notes for the following days:

- 4, 9, 12 14–19, 21–22, 27, and 30 Month2;
- 4, 6–7, 9, 11–13, 17, 19, 21, 23, 25–26, and 29 Month3; and
- 2, 4–7, 9, and 11 Month4.

[40] NCNZ, "Competencies for registered nurse scope of practice" (December 2007), Competency 2.3.

148. An incident report form was not completed after Mrs A's fall on 18 Month3. In addition, there are no notes recording the nursing staff's requests and communication with Dr F.

149. The importance of good documentation cannot be overstated. As noted in an earlier HDC opinion relating to the provision of residential care:[41]

> "The clear and accurate documentation of a resident's condition and the care provided is not optional. It is a means by which relevant information is shared between those providing care and treatment, and is a key component of effective teamwork."

150. I consider that the lack of documentation affected the care that Mrs A received, and breached professional standards. The documentation by the rest home's staff was suboptimal, and RN E must take personal responsibility for this. Accordingly, I consider that RN E breached Right 4(2) of the Code.

Personal care and hygiene — Breach

151. Ms C complained to the rest home about her concerns over the care provided to her mother, in particular, the number of times she found her mother drenched in urine or soiled. RN E told HDC that Mrs A ended up sitting in urine or faeces because there was a breakdown in communication between staff working different shifts.

152. In my view, this is unacceptable. Leaving Mrs A for an unreasonable length of time soiled or wet from urine could have compromised her health, and showed a lack of respect for Mrs A's dignity. As Clinical Nurse Manager, RN E was responsible for overseeing all nursing care, and she must take personal responsibility for this. For failing to respect Mrs A's dignity, I consider that RN E breached Right 3 of the Code.

Summary

153. In her role as registered nurse and Clinical Nurse Manager, RN E failed to comply with a number of the rest home's policies and procedures or meet the requirements of her job description or the competencies of a registered nurse.

154. RN E provided suboptimal care to Mrs A with regard to care planning, documentation, incident reporting and her monitoring, assessment, documentation and management of Mrs A's changing condition. Ms O'Connor stated:

> "While [RN E] may have recognised a change in [Mrs A's] needs she has not documented a comprehensive nursing assessment and subsequent use of the nursing process in care provision for these changes. Regardless of whether or not care was provided at any given time there is no written evidence to support verbal claims. She has also failed to recognise when further assessment or referral should be made regarding [Mrs A's] weight loss, falls, diabetic monitoring, rectal/vaginal prolapse and possible swallowing problems."

[41] See Opinion 08HDC17309 available at www.hdc.org.nz/publications.

155. Ms O'Connor considers these failings to be a severe departure from expected standards. I agree. In my view, for the reasons given above, RN E breached Right 4(1) of the Code for failing to provide services to Mrs A with reasonable care and skill.

156. RN E failed to document accurately the care provided to Mrs A. In doing so, RN E breached professional standards and Right 4(2) of the Code.

157. RN E also failed to provide services to Mrs A in a manner that respected her dignity, and breached Right 3 of the Code.

Inadequate assessment and evaluation — Adverse comment

158. On 23 Month2, Mrs A suffered a suspected TIA. RN E took Mrs A's observations at 10.30am and called the GP. Due to surgery commitments, the GP was unable to review Mrs A until 8.30pm.[42] RN E did not retake Mrs A's observations during the day. Ms O'Connor viewed RN E's clinical assessment of Mrs A on 23 Month2 to be substandard. In addition to taking Mrs A's observations, Ms O'Connor would have expected RN E to have conducted and recorded a detailed nursing assessment and to have communicated and recorded a plan of care for staff to implement. I am concerned that following such a serious incident, RN E failed to conduct a further assessment and did not take Mrs A's observations again.

Communication with family — Adverse comment

159. On 23 Month2, there was a six-hour delay in the rest home informing Mrs A's family about her suspected TIA. The rest home told HDC that RN E apologised to Ms C for the oversight and for not informing Ms C sooner. A six-hour delay in informing a resident's family of a serious health event is suboptimal. Although I do not find RN E to have breached the Code in this regard, I recommend that she reflect on these comments and amend her future practice accordingly.

Opinion: Ms D — Breach

160. Ms D is not a registered nurse and was employed as the Facility Manager at the rest home from the mid 1990s.

161. As the Facility Manager, Ms D had overall responsibility for ensuring a quality service was provided to residents. Ms D described her responsibilities as ensuring that the clinical care is provided by well-informed and trained staff. According to her job description, her responsibilities also included care planning, keeping all documentation up to date, and monitoring all accidents/incidents. In addition, the Age Related Residential Care Services Agreement (ARRC) (District Health Boards New Zealand, 2001) provides that the manager's role is to ensure that residents are

[42] I note that Ms C thought the GP reviewed Mrs A sometime after 10.30pm. It is not necessary for me to make a finding on this fact for the purpose of my decision-making.

adequately cared for in respect of their everyday needs, and that services provided to residents are consistent with legislative obligations and the ARRC.

162. There are a number of areas in which the care provided to Mrs A by the rest home was below the expected standard, and for which Ms D, as Facility Manager, must accept responsibility. As further discussed below, those areas included care planning, staff compliance with policies, documentation, and the reporting of incidents.

Care planning

163. In her interview with HDC, Ms D said that she worked with RN E to do the care planning. Ms D's job description also lists care planning as her responsibility. Therefore, as Facility Manager, Ms D must also accept responsibility for the deficiencies in Mrs A's care planning.

164. I repeat paragraphs 117 to 126 above in relation to care planning.

165. By failing to ensure that Mrs A's care plan was completed adequately, particularly in relation to the management of her various health issues, and by failing to ensure that Mrs A's care plan was updated when her condition changed, Ms D failed to comply with the rest home's care plan policy and her job description. As a result, Ms D did not provide care to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Incident reporting

166. In accordance with her job description, Ms D was responsible for monitoring all accidents and incidents and ensuring accident and incident forms were completed by staff and followed up.

167. I repeat paragraphs 139 to 142 above regarding Mrs A's falls and incident reporting.

168. I consider that by failing to ensure that the rest home staff completed incident forms and followed up adequately, Ms D did not provide care to Mrs A with reasonable care and skill. Accordingly, Ms D breached Right 4(1) of the Code.

Documentation

169. Ms D had an overall responsibility to ensure that the rest home's documentation was up to date. There does not appear to have been sufficient oversight at the rest home of compliance with documentation policies and standards.

170. I repeat paragraphs 146 to 149 above regarding the lack of documentation.

171. As Facility Manager, Ms D should have identified that standards were not being met, and should have taken steps to improve the quality of documentation at the rest home. I consider that the lack of documentation affected the care that Mrs A received. The documentation by the rest home's staff was suboptimal, and Ms D must also take personal responsibility for this. Accordingly, I consider that Ms D breached Right 4(1) of the Code.

Summary

172. In my view, Ms D did not provide care to Mrs A with reasonable care and skill by:

a) failing to ensure that Mrs A's care plans were completed adequately and remained updated when her condition changed;
b) failing to ensure that the rest home staff completed incident forms and followed up adequately; and
c) failing to ensure that Mrs A's documentation was kept up to date.

173. Accordingly, Ms D breached Right 4(1) of the Code.

Opinion: The Willows Rest Home Ltd

174. As detailed above, the New Zealand Health and Disability Sector Standards (NZHDSS) require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely, appropriate, and safe services to consumers.

175. Mrs A had the right to expect that The Willows Rest Home Limited and its staff would provide her with care to an appropriate standard. As identified above, The Willows Rest Home Limited's staff did not provide services to Mrs A with reasonable care and skill. I have carefully considered the extent to which the deficiencies in Mrs A's care occurred as a result of individual staff action or inaction, as opposed to systems or organisational issues.

Care and treatment — Breach

176. While I have identified my concerns about the actions of RN E and Ms D, The Willows Rest Home Limited had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and that complied with the Code. That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to.

177. As noted above, aspects of the services provided to Mrs A were suboptimal. Mrs A's care plan was incomplete and was not kept updated. Her changing condition was not adequately monitored, assessed or managed by staff. The Willows Rest Home Limited's staff also failed to complete incident forms or follow up incidents adequately.

178. While The Willows Rest Home Limited had policies for care planning, documentation, incident reporting and nutrition and hydration, it appears that staff failed to comply with those policies. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggests an environment and

culture that do not sufficiently support and assist staff to do what is required of them.[43] Without staff compliance, policies become meaningless.[44]

179. The Willows Rest Home Limited had a responsibility to provide Mrs A services with reasonable care and skill, and it failed to do so in this case. Accordingly, I consider that The Willows Rest Home Limited breached Right 4(1) of the Code.

Documentation — Breach

180. The NZHDSS require that consumer information is "uniquely identifiable, accurately recorded, current, confidential, and accessible when required".[45] In my view, this includes ensuring good clinical records are kept and documentation remains up to date. This is essential to providing good care of an appropriate standard.

181. I repeat paragraphs 146 to 149 above regarding the lack of documentation.

182. In addition, the NZHDSS require all adverse events to be recorded, and reported to the consumer and, where appropriate, the consumer's family.[46] An incident report form was not completed after Mrs A's fall on 18 Month3, and the family was not contacted.

183. The Willows Rest Home Limited's documentation did not meet the NZHDSS and fell well below an acceptable standard. Accordingly, I consider that The Willows Rest Home Limited breached Right 4(2) of the Code.

Communication — Breach

184. Mrs A's Care Plan was incomplete and was not kept updated. As a result, Mrs A's Care Plan failed to communicate her needs to the rest home's staff effectively. There were also lapses in communication between the rest home staff and in their communication with Dr F. Between 11 Month3 and 8 Month4, there is no evidence that Dr F was contacted by the rest home staff about Mrs A's rapid weight loss or her change in condition. In addition, there is no record of the information the rest home staff provided to Dr F on the occasions when he was called to review Mrs A.

185. In addition, I note that the Facility Manager and Clinical Nurse Manager had the same job description. It is unclear who was responsible for what, whether the Facility Manager and Clinical Nurse Manager understood their different responsibilities, or whether the rest home staff had a clear understanding of the different roles. The lack of clarity around roles and responsibilities would have affected the ability of the rest home staff to communicate effectively with management.

186. In my view, the rest home staff failed to communicate effectively with one another and with Dr F to ensure that Mrs A received quality and continuity of services. Accordingly, I find that The Willows Rest Home Limited breached Right 4(5) of the Code.

[43] Opinion 07HDC16959 and Opinion 10HDC00308 available at www.hdc.ord.nz/publications.
[44] Opinion 09HDC01974 available at www.hdc.ord.nz/publications.
[45] NZS 8134.1:2008, Standard 2.9.
[46] NZS 8134.1:2008, Standard 2.4.

Medication administration — Adverse comment

187. On 8 Month4, Dr F reported that Mrs A had oral thrush and prescribed Daktarin gel to be used four times per day for one week. The administration record shows that a number of doses of Daktarin gel were missed or not recorded. It is important that residents receive their medication and that it is administered and recorded appropriately. The rest home did not ensure that this was done.

188. It is unclear from the job descriptions provided by the rest home who had responsibility for the administration of medication. I note Ms O'Connor's comment that she is "unsure whether the responsibility to ensure medications are administered as prescribed lies with the Manager or Nurse Manager role in this facility. But from a quality perspective it should have been identified and addressed." I note that the rest home now has separate job descriptions for the Facility Manager and Clinical Nurse Manager. The responsibility for overseeing the administration of medication now clearly lies with the Clinical Nurse Manager.

Mrs A's diet — Adverse comment

189. Mrs A's family had concerns about the type of food that Mrs A was fed during her stay at the rest home, and that her menu, completed by Ms B on admission, was not followed. I am unable to make a finding as to what Mrs A was or was not fed. However, I am concerned at the delay in assessing Mrs A's diet and hydration needs and, in addition, I am critical of the lack of documentation about Mrs A's diet.

Opinion: RN G — Adverse comment

190. On admission, RN G took Mrs A's baseline observations but did not take her temperature or oxygen saturation. This meant that there was no baseline for comparison with future readings. RN G also recorded a high pulse (138bpm) but did not undertake any further assessments or monitoring, nor did she inform Mrs A's GP. My expert advisor, Margaret O'Connor, informed me that given Mrs A's high pulse, further assessment was required.

191. On 12 Month4, RN G documented Mrs A's temperature as being 94.2°F (34.6°C). RN G did not follow up this abnormally low reading.

192. RN G is an experienced registered nurse, and it is clear that there were some inadequacies in the care she provided to Mrs A. While I do not consider that this amounts to a breach of the Code in this case, I consider that RN G should reflect on her contribution to the poor care provided to Mrs A.

Recommendations

193. The changes made by the rest home since and/or in response to these events, as outlined in paragraphs 103, 105, 106, 108, and 110 of this report, are noted.

194. In addition to those changes, I recommend that the rest home:

a) Provide an update on staff compliance with its policies and procedures.
b) Provide an update on its monthly care planning and registered nurse communication book audits implemented since these events, including the results of the last audit for each undertaken.
c) Introduce a separate weight chart/graph for each resident.
d) Conduct staff training on the appropriate use of bowel charts, and conduct an audit of its bowel charts.
e) Provide HDC with an update on these matters by **11 July 2014**.

195. I also recommend that the Nursing Council of New Zealand carry out a competence assessment of RN E.

196. Ms D, on behalf of herself and the rest home, and RN E have provided written apologies for forwarding to Mrs A's family.

Follow-up actions

197.
- RN E will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Willows Rest Home Limited, will be sent to the Nursing Council of New Zealand, and it will be advised of RN E's name. As noted above, I have also recommended that the Nursing Council carry out a competence assessment of RN E.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Willows Rest Home Limited, will be sent to the District Health Board, the New Zealand Aged Care Association, and the Ministry of Health.

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

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from an independent nursing advisor, Margaret O'Connor:

"I have been asked to provide an opinion of whether [the rest home], its Nurse Manager (NM), [RN E], and Manager (M), [Ms D], provided an acceptable standard of appropriate care to the late [Mrs A] for the period of 20 [Month1] to 18 [Month4]. I have read the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Professional profile
Since registering as a Comprehensive Nurse in 1988 I have completed a Bachelor of Nursing (2001), Graduate Certificate in Hospice Palliative Care (2002) and a Masters of Nursing with a clinical pathway (2009). My initial nursing experience was as a Public Health Nurse after which I moved to the hospital setting first in orthopaedic nursing then acute/general medical in a rural hospital. Following this I embarked on an overseas trip where I worked firstly as an agency nurse in various hospital wards then in the community setting as a district nurse in London. Also in London, I worked for 9 months in a Nursing Home for older people before returning to New Zealand and commencing nearly 5 years in Assessment, Treatment and Rehabilitation. In this setting, I coordinated a 12 bed unit and completed needs assessments for older people in a large geographical area. From 1997 to 2011 I worked for a non-profit charitable organization managing various aged care facilities. Most recently I managed a retirement village of 60 beds; residential, hospital and dementia levels, and 21 cottages. I was chair of the facility's Quality team and the organization's Clinical Practice Group and managed my facility through many changes in care provision and enjoyed successful audits. Currently I am a Nurse Practitioner for Older Persons Health in a joint initiative between a District Health Board and a non-profit charitable organization. I am a member of the New Zealand College of Nurses and enjoy providing education and insight into care of the older person for various groups in my region.

Background
[Mrs A] was admitted to [the rest home] on 20 [Month1] from a [public hospital] where she had been an inpatient since 8 [Month1] and was being treated for a scalp laceration as a result of a fall. [Mrs A] was discharged to another facility on 18 [Month4] at her daughter's request.

[She was admitted to hospital] with terminal urosepsis and renal failure secondary to infection. [Mrs A] died [four days later].

[Ms C] and [Ms B] complained about the care provided to their mother, [Mrs A] at [the rest home].

The documentation I have reviewed is extensive and includes not only documentation from [Mrs A's] time at [the rest home] but responses to preliminary investigation and interviews. Documents include

In **part A**:

a. Complaint documentation, including:
   i. Photograph of first (handwritten) complaint lodged with [the rest home];
   ii. Emailed complaint 15 [Month4];
   iii. Response to email 21 [Month4];
   iv. Complaint to HDC received [date] ([Ms C]);
   v. Complaint to HDC received [date] ([Ms B])

b. Notification of investigation letters:
   i. dated 25 July 2012 ([the rest home] and [RN E]);
   ii. dated 14 March 2013 ([Ms D]).

c. Correspondence from family, including:
   i. Email from [Ms C] 12 October 2012;
   ii. Email from [Ms C] 6 November 2012;
   iii. Interview summary dated 10 October 2012.

d. Correspondence from [the rest home], including:
   i. Letter received 30 September 2011 (including letter from [RN G]);
   ii. Letter received 20 February 2012;
   iii. Two emails received 9 July 2012;
   iv. Letter received 15 August 2012;
   v. Email received 21 November 2012;
   vi. Letter received 7 January 2013 (dated 18 December 2012);
   vii. Interview summary dated 10 October 2012.

e. Correspondence from [Dr F], including:
   i. Letter received 11 October 2012 (including attachments and clinical notes);
   ii. Amended interview summary received 12 November 2012.

f. Correspondence from [the] District Health Board, including:
   i. Email from Clinical Head — Emergency Care 29 September 2011;
   ii. Letter received 10 October 2011, including clinical notes.

g. Correspondence from [RN E], including:
   i. CV for [RN E];
   ii. Letter dated 25 September 2011;
   iii. Response to notification, dated 5 August 2012 (including attachments);
   iv. Training certification;
   v. Interview summary dated 10 October 2012.

h. Correspondence from [Ms D] including:
   i. Response to notification received 8 April 2013;
   ii. CV for [Ms D];
   iii. Training certification.

In **part B**:

a. Letter dated 26 October 2012, including:
   i. Education/training
   ii. Medication charts
   iii. Meeting minutes 17 [Month4]
   iv. Insect treatments 2011
   v. Job descriptions
   vi. RN book sample
   vii. GP book sample
   viii. Day book sample
   ix. Staff roster
   x. Example bowel record
   xi. Example new incident report
   xii. Example new short term care plan

b. Progress notes for [Mrs A]:
   i. Transcribed notes
   ii. Multi-purpose chart
   iii. Blood pressure chart
   iv. Pain assessment
   v. Pain chart
   vi. Hospital documentation
   vii. Diet profile
   viii. Complaint correspondence
   ix. Audit documentation detailing this complaint
   x. Bladder training
   xi. Incontinence documentation and assessments
   xii. Medication administration record
   xiii. Integrated notes
   xiv. Policy on resident falls, July 2010
   xv. Falls risk assessment
   xvi. Pressure risk assessment
   xvii. DHB documentation — patient transfer
   xviii. Nursing assessment (admission)
   xix. Incident report 24 [Month2], 11 [Month2]
   xx. Laboratory report
   xxi. Initial nursing care plan
   xxii. Care plan
   xxiii. Daily care review
   xxiv. Staff training — Hygiene/Personal Care

In **part C**:

   b. Compliment form
   c. Audit documentation
   d. Complaint documentation
   e. Protocol book
   f. Job description templates

g. CANZ membership certificate
h. In service education
i. Care plan audit
j. Highlighted incident form template

Policies:

k. Assisting a resident to eat; weight loss
l. Dietary policy
m. Staff induction/orientation
n. Formal reporting lines of communication
o. Staff communication policy
p. Staff handover
q. Communication with residents/relatives
r. Residents meetings
s. Residents use of telephone
t. Staff meetings
u. Approved abbreviation list
v. Nursing objectives
w. Accidents and incidents policy
x. Resident falls
y. Adverse events
z. Care plans

[The rest home]

Care Planning
The initial care plan was completed on 2[0] [Month1] by NM [RN E] within the time frames required by policy. It appears the long term care plan was completed, also by NM [RN E], on the same day whereas the policy states this is to be done within the next 1–2 weeks when staff have more knowledge of residents' needs. The policy also states the care plan should be updated when health needs change but it appears no changes were made to this document after its initial formation. Also, there is no evidence of a short term care plan for the change in [Mrs A's] health needs after the health event on 23 [Month2].

I find the care plan to be deficient in several areas including

1. Management of [Mrs A's] diabetic status and dietary needs related to this
2. Adequacy of interventions for dietary needs e.g. diabetic diet, weight loss
3. Management of rectal/vaginal prolapse
4. Difficulty in swallowing and nursing interventions to manage this and prevent complications
5. [Mrs A's] 'severe dementia' (as per GP's notes) and her needs regarding this except to redirect her if she gets lost.

Under the Age Related Residential Care Services Agreement for the provision of Residential Care for this time, which also reflects the required Health and Disability Services Standards (8134.1.3.5, 2008), Providers need to ensure:

D16.3

(a) Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status

(g) The Care Plan addresses the Subsidised Resident's current abilities, level of independence, identified needs/deficits and takes into account as far as practicable their personal preferences and individual habits, routines, and idiosyncrasies;

h) The Care Plan addresses personal care needs, health care needs; rehabilitation/habilitation needs, maintenance or function needs and care of the dying

j) Each care plan focuses on each Subsidised Resident and states actual or potential problems/deficits and sets goals for rectifying these and details required interventions

k) Short term needs together with planned interventions are documented by either amending the Care Plan or as a Short Term Care Plan attached to the Care Plan

l) Care plans are available to all staff and that they use these care plans to guide the care delivery provided according to the relevant staff member's level of responsibility.

D16. 4 Evaluation

(a) You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, whichever is the earlier

It is my view, given the documentation I have reviewed that nursing staff have failed, on occasion, to respond to [Mrs A's] changing needs particularly weight loss, swallowing problems, falls and the health event of 23 [Month2]. This is evidenced by the lack of assessment (observations, fluid input and output and weight), planning and implementing interventions and evaluating their effectiveness. All registered nurses are accountable for [Mrs A's] care during her stay and have a responsibility to complete this and report to the NM for clinical support. NZNC says in defining the registered nurse scope of practice that they 'provide comprehensive nursing assessments to develop, implement, and evaluate an integrated plan of health care, and provide nursing interventions that require substantial scientific and professional knowledge and skills' (p.3, 2004).

Assessment and monitoring of [Mrs A]

NM [RN E] has recorded in the Nursing Assessment, page 7, that [Mrs A] suffered from back pain probably due to Osteoarthritis. This is also identified in the Care Plan, page 9. A pain assessment was completed on 31 [Month2] and a monitoring chart was completed till 6 [Month3] due to back ache in the mornings. It identifies that [Mrs A] required Paracetamol, as an appropriate intervention, two mornings in a row. This is very appropriate. There is no signing place to identify who completed this assessment on the form and the use of Paracetamol is not cross referenced in the progress notes.

The Blood Pressure Record Sheet shows appropriate monthly recordings of Blood pressure, pulse, and weight. There is no separate weight chart/graph which may have been more helpful in tracking weight changes.

Multi purpose chart shows observations completed

1. 20 [Month1] on admission
2. 23 [Month2] at 1030 and 2200hours
3. 24 [Month2] at 0100 and 0530 hours

On 20 [Month1] [Mrs A's] pulse was recorded at 132 by [RN G] and no further mention has been made of this nor was the assessment repeated to ensure that this heart rate was not maintained. A pulse rate of above 100 beats per minute is known as tachycardia and should have been assessed further. There appears to be no follow up discussion with the GP on his initial visit the next day.

A urinalysis was collected on 25 [Month2] and 14 [Month3].

[Mrs A] had Type 2 Diabetes Mellitus (clearly stated on [the DHB's] transfer documentation dated 20 [Month1]) and required a diabetic diet and an oral hypoglycaemic twice daily to manage this. There is no care plan for monitoring of her diabetic status at [the rest home], NM [RN E] completed the long term care plan. I can find no blood glucose monitoring in the documentation provided and no request from the GP not to monitor her blood glucose even on a random basis. Her HbA1c on 11 [Month4] was 54 and her blood glucose was 8 and 6.3 on 2 [Month2]. All are acceptable but it is prudent to monitor this at a facility level particularly at admission for a baseline and randomly afterwards particularly if there are health status changes.

A Falls assessment was completed on 20 [Month1] and 10 [Month4] with 'High risk' outcomes both times. Pressure Risk assessments were completed on the same days with an 'At risk' outcome. I do question the outcome of the second assessment as it does not reflect her weight loss and perhaps change in appetite. Neither of these forms have spaces for signatures for those completing them.

A Continence assessment was commenced on 14 [Month4] by [RN G] and states 'no Urinary tract infections past 6 months'. A urinalysis completed on 25 [Month2] and 14 [Month3] were both negative for indications of infection

(positive for both nitrates and leucocytes, Bpac guidelines 2006 and 2013). The Daily care review notes do indicate monitoring of toileting and passing of urine.

On 21 [Month1] an entry in the progress notes states [Mrs A] was having difficulty swallowing 'big tablets'. There is no mention of this being an issue in the discharge notes from [the DHB] or that [Mrs A] required any Speech language therapy input while an inpatient. Nursing assessment on admission states speech slow and slurred at times and does not identify swallowing difficulties except 'gets frothy in mouth and tends to hold spit in mouth'. GP assessment on 15 [Month4] states 'seems to have problems swallowing' '?eating and drinking well'. These notations indicate at least two times that it may have been prudent to assess [Mrs A's] swallow further. [The rest home's] Resident nutrition and hydration policy requires any resident with 'problems swallowing' to have thickened fluids yet this is not a planned intervention in [Mrs A's] care plan. The nursing staff and particularly NM [RN E] have responsibility to instigate further assessment and interventions as appropriate.

On 27 [Month3] it is recorded that [Mrs A] had 'problems standing' and on 6 [Month4] she is reported as 'getting more and more stiff standing' no further interventions/assessments are recorded by registered staff.

Management of [Mrs A's] nutrition and weight loss

The Resident nutrition and hydration policy requires a special diet to be recorded in the care plan and I see no evidence of a diabetic diet being required by [Mrs A]. The Admission notes say to also see the diet profile however no evidence is found of one being completed on admission. However, on 26 [Month2] a Resident diet profile was completed stating [Mrs A] needed both a puréed and soft diet. This was not mentioned in progress notes as to why the profile was completed and care plan was not changed to match.

Weight is recorded on admission as 62kg and this was maintained on 28 [Month2] then dropped to 58 kg on 18 [Month3] and 58.6kg on 16 [Month4]. Between [Month1] and [Month2], a period of a month, there was a weight loss of 4kg and no acknowledgement of this trend was recorded and any interventions planned in response. Suitable interventions would have the introduction of a food chart to identify intake, weekly weighs, supplementation and referral to the GP and/or Dietician. Daily care review notes request staff record dietary intake as in good or small which occurred on the forms reviewed. On 27 [Month3] it is recorded that she was not eating much. Policy 8.0 'Assisting a resident to eat' states that when a resident suddenly starts to lose weight reasons should be investigated. "Malnourished residents are to have dietary support"'. NM [RN E] states in her interview with HDC staff that 'Sustagen' was started but I have not found any evidence to support this in the documentation.

In summary I do not feel that [Mrs A's] weight loss and dietary requirements were managed appropriately. I feel the Policy and procedures relating to a Resident's weight and diet are not specific enough to assist staff in identifying a problem. I recommend [the rest home] utilise the RN care guides for Residential Aged Care

'Nutrition and Hydration Care guide' (www.wdhb-agedcare.co.nz) to review their policies.

Management of [Mrs A's] bowel function

[Mrs A's] care plan page 8 completed 21 [Month1] by NM [RN E] states 'prone to constipation and incontinence if not toileted'. However the supplied medication chart shows no aperients commenced till 11 [Month4]. I'm assuming this could be an updated chart as progress notes on 29 [Month2] show she was given Lactulose. The Admission document, page 5, states that 'due to prolapsed rectum [Mrs A] takes aperients to aide with her bowel cares' under describe bowel patterns it states 'with [Mrs A] it can go either way'. The care plan is not specific about [Mrs A's] bowel management or how to manage her rectal/vaginal prolapse. On 24 [Month1] a HCA recorded she treated [Mrs A's] rectal/vaginal prolapse with a cold compress and then on 26 [Month1] it was 'pushed back by [RN G]'. Discussion with [Mrs A's] GP on management of the prolapse and care planning of his recommendations would have been appropriate.

[Mrs A's] bowel movements are recorded on her daily care review of which 13 [Month3] to 17 [Month4] only was reviewed. Bowels were recorded as opened as below (normal unless stated). The legend was not always used correctly by staff so Y on the form was interpreted as Normal.

Dates	**Number of times**	**Dates**	**Number of times**
13 [Month3]	1	1 [Month4]	
14 [Month3]	1	2 [Month4]	1
15 [Month3]	1	3 [Month4]	1
16 [Month3]	1	4 [Month4]	
17 [Month3]	1	5 [Month4]	1
18 [Month3]		6 [Month4]	1
19 [Month3]	2 — firm	7 [Month4]	Small x2
20 [Month3]		8 [Month4]	2 — firm
21 [Month3]	2	9 [Month4]	Small
22 [Month3]	2	10 [Month4]	2
23 [Month3]	2	11 [Month4]	1
24 [Month3]		12 [Month4]	Small & incont

25 [Month3]	2	13 [Month4]	Small & incont & normal
26 [Month3]	2 — firm	14 [Month4]	1
27 [Month3]		15 [Month4]	1
28 [Month3]	2 — enema given	16 [Month4]	1 & firm
29 [Month3]	1 — supp given	17 [Month4]	1
30 [Month3]	1		

This record shows that [Mrs A's] bowels moved regularly generally every 1–2 days. In the progress notes she was given an enema on 28 [Month2] and a glycerine suppository on 29 [Month2]. No result is recorded in the progress notes but is on the daily care review. There is no mention in the progress notes of [Mrs A] being constipated however the GP states on 8 [Month4] that [Mrs A] was constipated still. He added Movicol and Laxsol 2 twice daily as required and this was commenced on 11 [Month4]. No signing sheets have been provided to assess whether they were given and there is no record in the daily notes as to whether they were needed and given. The episodes of diarrhoea recorded may have been related to constipation but it is difficult to assess from information given. I do recommend the use of Bristol Stool Chart to ensure trending can be more easily recognised.

Actions taken in light of falls 11 and 24 [Month2]
[Mrs A] experienced a fall at 1620 hours on 11 [Month2] and a possible slip out of her chair at 1620 hours on 24 [Month2]. Incident forms were filled out following these falls and state that family was informed after the 11 [Month2] fall at 1700 hours but not after the 24 [Month2] incident. The Protocol book states observations must be completed after falls but these were not recorded for 11 [Month2]. Another fall is recorded in Progress notes on 18 [Month3] and no observations are recorded for this fall.

Management of Falls Policy says 'if a resident falls frequently (more than twice in a month) a complete multi disciplinary review' should be completed. This is not recorded as initiated at any stage. I assume it would be the clinical responsibility of NM [RN E] to initiate this.

Actions towards [Mrs A's] health status 23 [Month2]
The progress notes record that NM [RN E] completed the initial assessment with [Mrs A] when she was told [Mrs A] had slept through morning tea. She completed observations at 1030 hours and twice the next day and [RN G] completed one assessment at 2200 hours on 23 [Month2]. These observations recorded on the

Multi purpose chart show a sustained subnormal temperature of 34^{6} ºC to 35^{7} ºC. [Mrs A's] temperature was not assessed on admission by [RN G] therefore there was no baseline for comparison. Instructions on the chart clearly show 37^{o}C to be considered acceptable and that in case of lower as assessed here, the RN is to be informed. No record is made of further interventions for this including discussion with the GP during his visit that evening. [Mrs A] was verbally assessed for pain through the night by the staff.

[RN G] stated in progress notes that she tried to contact daughter [Ms C] after GP's visit at 2030 hours. There is no record of either the GP or RN discussing the event and possible diagnoses with [Mrs A's] family although permission was sought for bedrails. The GP states that he thinks [RN G] contacted the family later that shift however it is not recorded.

On 23 [Month2] the GP stated in the progress notes he thought [Mrs A] to be mildly dehydrated. No further assessment is made or interventions planned by [RN G] on duty at the time or NM [RN E] the next day. The introduction of a fluid input chart would have been expected at the least to gauge [Mrs A's] input and plan accordingly if insufficient. NM [RN E] does state 'fluids well tolerated' on 24 [Month2]. The Daily care review does ask for amount taken each shift and for those I reviewed 13 [Month3] to 17 [Month4] [Mrs A] had a good (over 750mls) or Fair (over 500mls) intake. I assume these are not measured totals merely an assumption made by staff. The Resident nutrition and hydration policy states that 'if there is a problem with fluid intake a fluid balance chart will be introduced'. I have found no evidence of this and do not consider her 'mild dehydration' to have been managed appropriately by the registered staff.

The GP did review [Mrs A] on 26 [Month2], 8 [Month4] and 15 [Month4] which was very appropriate. Unfortunately I find the level of clinical assessment completed by NM [RN E], who reviewed [Mrs A] initially, to be substandard in her response to [Mrs A's] change in health status. I believe a registered nurse in a clinical position such as Nurse Manager should be able to complete a detailed assessment and report it in a structured manner e.g. Subjective and objective findings, assessment (diagnoses) and plan of care for staff to implement. Unfortunately there were no instructions to staff recorded in the care plan or progress notes. Added to this, no other Registered Nurse has done this either and as previously stated it is within their scope. NM [RN E] has not recorded communication with the GP or a visit request.

Response to [Dr F]'s request 26 [Month2]
A urinalysis was collected on 25 [Month2]. GP did review on 26 [Month2] but the staff have not recorded any discussion from the review. The GP has not recorded a request for a MSU or bloods in the progress notes merely to chase the MRI results. He states in his response that he made requests for bloods and a MSU was this of the lab? Lab report shows Full blood count on 8 [Month3] and they were awaiting MSU specimen. There is no mention in the progress notes of this needing to be collected by staff.

Adequacy of documentation by staff
I have reviewed [Mrs A's] integrated progress notes and daily care review forms and examples of the Day book and Doctors book. Documentation requirements as outlined in the Protocol book state that staff are required to write in the resident's integrated notes each shift. It appears there is no documentation in the integrated progress notes for the following days;

4, 5, 6, 7, 8, 12, 14, 15, 16, 17, 18, 19, 21, 22 and 27 [Month2]

4, 6, 7, 9, 11, 12, 13, 17, 19, 21, 23, 25, 26 [Month3]

4, 5, 11 [Month4]

There are also some discrepancies in chronological order i.e. 24 [Month1] to 13 [Month3] and 30 [Month1] to 27 [Month1].

I find the documentation in this case so poor it has been difficult to build a clinical picture of this lady's needs during her time at [the rest home]. Day to day reporting is evident except on missed days but important clinical assessments and plans for care are not evident. Perhaps the use of the Daily Care review form diminishes what is recorded in the integrated progress notes.

Communication by staff

1. Communication to [Dr F]
I am unsure of communication with [Dr F] as staff have not recorded this in progress notes. Having not been able to review the Doctors book for this period I am unsure of staff's written communication to him. He visited on 23 [Month2], 8 [Month4], and 15 [Month4] and has made notes on these visits but no RN has followed up with a report or further instructions etc.

2. Communication to family
The policy for falls state that family are to be notified of falls. I can find little documentation around communication with family and certainly no meeting after [Mrs A's] health event on 23 [Month2] which might have been useful for informing family of GP's assessment and discussing future planning.

I consider it the Manager or Nurse Manager's job to ensure this communication occurs and it is recorded appropriately, as does their job descriptions, and find no evidence that it did. Competency 3.2 of a registered nurse states that the RN acknowledges family/whanau perspectives and supports their participation in services (NZNC, p.26, 2007).

Adequacy of Policies and procedures
On the whole these appeared adequate, with the exceptions already mentioned, however I would recommend utilizing the RN care guides for Residential Aged Care (www.wdhb-agedcare.co.nz) and the recommended forms within these are considered best practice for Residential Aged Care Facilities in New Zealand now.

For document control the date of adoption of Policies and procedures is recommended at the bottom of the form and indicates when a 2 yearly review is due.

Adequacy of Orientation and staff training
I have reviewed the Staff induction/orientation policy, staff orientation, training of new staff and Staff orientation signing sheet, orientation check list for caregiver's/ ancillary staff, Health and safety induction training and all appear adequate to meet requirements of the contract, standards and facility. The individual Training Records appear to cover compulsory requirements and auditing should have identified any deficiencies in their latest HealthCert report.

The training records for NM [RN E] and [RN G] are very detailed and appear to cover compulsory topics. It appears most of this training is mandatory and perhaps not of the clinical calibre you might expect an RN in this position to be attending.

Adequacy of changes made by [the rest home] as a result of the incident
I have reviewed the list supplied by Manager [Ms D] regarding changes and auditing completed since the complaint was made. She is to be commended on her investigation and these changes particularly the incident form and new communication books. I have made some further recommendations throughout my report.

Nurse Manager — [RN E]
[RN E] states in her CV she was initially employed at [the rest home] as a Health care assistant ([five years]) while she became a registered nurse [date]. After working as a RN she then took on the job as Nurse Manager [date]. The job description for this position was signed [5 years later]. Manager [Ms D] has been unable to supply any orientation for NM [RN E] as she started at [the rest home] prior to [a] takeover. However she was appointed NM by Manager [Ms D] therefore some orientation to this new position and [the rest home] expectations should have been provided.

NM [RN E] has admitted that she did not notify [Mrs A's] family of her health event on 23 [Month2] until they arrived into visit and gives no explanation as to why. She was involved on this day in assessing [Mrs A] as early as 1030 hours. In her job description it is clearly her role to communicate with families. There is some conflicting information from NM [RN E] and [Mrs A's] daughter around events of that day but that does not change the fact that the family should have been notified earlier.

According to [Mrs A's] discharge summary she was still on Nilstat medication when she was admitted to [the rest home] from Hospital and it is possible that the Nilstat found in her drawer was possibly from then. This should not have been stored there in the first place and should have been discarded when the course completed. This was possibly NM [RN E's] responsibility overall.

NM [RN E's] job description, number 3, states she was responsible for direct care and nursing documentation. As previously stated I have found NM [RN E's]

clinical assessment and subsequent use of the nursing process in her documentation to be lacking. While she may have recognised a change in [Mrs A's] needs she has not documented a comprehensive nursing assessment and subsequent use of the nursing process in care provision for these changes. Regardless of whether or not care was provided at any given time there is no written evidence to support verbal claims. She has also failed to recognise when further assessment or referral should be made regarding [Mrs A's] weight loss, falls, diabetic monitoring, rectal/vaginal prolapse and possible swallowing problems. I would consider this a severe departure from expected standards.

Manager — [Ms D]

In a response Manager [Ms D] states that she is responsible for quality of care, ensuring compliance within [the rest home] and also staff training. Therefore in her quality role of auditing of care planning and documentation she should have identified shortfalls and addressed these within the quality process.

I have found that in the recording of administration of Daktarin [Mrs A] did not receive scheduled doses as below

Twice on evening 12 [Month4]
Once evening of 14 [Month4]
Three times on 15 [Month4]
Once early evening of 17 [Month4]
Once morning of 18 [Month4]

I am unsure whether the responsibility to ensure medications are administered as prescribed lies with the Manager or Nurse Manager role in this facility. But from a quality perspective it should have been identified and addressed.

It appears Manager [Ms D] also had a responsibility to ensure she provided orientation for staff and ongoing support for development. Therefore, ongoing support for clinical development, over and above compulsory training, should have been provided for NM [RN E] and the registered staff. Without in depth detail of clinical courses attended I am unable to determine whether or not this is provided. Also there has been no orientation documentation provided for NM [RN E's] move from registered nurse to NM.

Manager [Ms D's] initial addressing of the complaint was appropriate and timely.

Summary

In summary, I find the evidence of care provided in the documentation to fall short of required standards. It is my opinion that the use of the nursing process; assessment, planning, implementation and evaluation, and subsequent care planning by NM [RN E] and the registered staff caring for [Mrs A] to be insufficient. Also of concern was the level of communication provided to this family. This would be viewed by nursing colleagues and monitoring bodies with moderate disapproval as it is within the competencies of every registered nurse.

Margaret O'Connor, NP, MN"