Metlifecare Wairarapa Ltd

Nurse Manager, Ms D

Registered Nurse, Ms E

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC00686)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In late 2010, Mr A was admitted to Metlifecare Wairarapa Limited (MLW), having been assessed as requiring hospital-level care. MLW's admission notes and care planning for Mr A took account of his complex medical history, including Type II diabetes.

2. Mr A's weight on admission to MLW was 68.8kg. He was not weighed again for three months, by which time he had lost 13.1kg: 17.5% of his body weight. Staff had not been instructed to monitor his fluid and food.

3. Mr A was assessed as a high risk for falls, and fell multiple times while a resident at MLW. No plan to manage his falls was developed.

4. Mr A was also assessed as a very high risk for developing pressure sores. Between 20 Month 5 and 13 Month 6 2011, Mr A's skin integrity deteriorated, and he developed wounds on both heels, and on his sacrum, bottom and shin. Although the wounds were treated, the treatment was not recorded, monitored or evaluated in accordance with MLW's policy.

5. Mr A's blood sugar levels (BSLs) were unstable. During the period that Mr A was a patient at MLW, he was admitted to the public hospital on several occasions for dehydration and elevated BSLs, recurrent urinary tract infections, and sepsis. One particular hypoglycaemic episode on 8 Month 6 was poorly handled by the duty registered nurse (RN), who tried to feed Mr A while he was unresponsive, causing him to choke.

6. There was no evidence that staff at MLW discussed Mr A's weight loss, frequency of falls, or wounds with medical staff, until a severe wound was noted in Month 8.

7. Mr A's wounds became necrotic. His condition continued to deteriorate, and he died on 12 Month 8.

Decision

8. Mr A's weight and hydration levels were not adequately monitored, and his wound care was poorly coordinated. Inadequate steps were taken to manage his falls, and there was poor communication between MLW nursing/care staff and medical staff. Care planning and documentation also fell below the requisite standard.

RN E

9. RN E, as senior registered nurse, was responsible for ensuring that Mr A was provided with adequate care and support. RN E failed to fulfil her role in regard to ensuring that Mr A's weight loss, hydration and pressure ulcers were adequately assessed and appropriate care plans put in place. However, her excessive workload, and the lack of continuity and fragmentation of the clinical management systems in place at MLW in 2010 and 2011, impacted on her practice. Accordingly, it was held that the deficiencies in her care did not amount to a breach of the Code.

Ms D

10. Nurse Manager Ms D had overall responsibility for supporting and managing the clinical team to ensure that a quality service was delivered to patients. In this regard, Ms D failed Mr A. However, Ms D's care was limited by her scope of practice, her workload was excessive, and she was operating in an environment that did not have adequate systems in place to ensure that she was able to fulfil her role. Therefore, it was held that the deficiencies in her care did not amount to a breach of the Code.

Metlifecare Wairarapa Ltd

11. MLW did not ensure there was adequate clinical oversight or orientation for its staff, or that staff complied with its policies. MLW therefore failed to provide services to Mr A with reasonable care and skill and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

RN I

12. RN I did not assess and manage Mr A's hypoglycaemic episode on 8 Month 6 adequately. However, the deficiencies in her care did not amount to a breach of the Code.

Complaint and investigation

13. The Commissioner received a complaint from Mrs B about the services Metlifecare Wairarapa Limited provided to her father, Mr A. The following issues were identified for investigation:

- *Whether the care provided to Mr A by Metlifecare Wairarapa Limited between Month 3 and Month 8 was appropriate.*
- *Whether the care provided to Mr A by Nurse Manager Ms D between Month 3 and Month 8 was appropriate.*
- *Whether the care provided to Mr A by Registered Nurse Ms E between Month 3 and Month 8 was appropriate.*

14. An investigation was commenced on 7 March 2012. 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.

15. The parties involved in the investigation were:

Mr A	Consumer
Mrs B	Complainant/consumer's daughter
Mrs C	Complainant/consumer's daughter
Ms D	Provider/Nurse Manager

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

RN E	Provider/registered nurse
Metlifecare Wairarapa Limited	Provider

Also mentioned in this report:

Dr F	General practitioner
Ms G	Key worker
RN H	Diabetic nurse specialist
RN I	Registered nurse

16. Independent expert advice was obtained from Mrs Jan Grant, a registered nurse with expertise in aged care (**Appendix A**).

Information gathered during investigation

Background

17. On 13 Month 1, Mr A (aged 89 years) was admitted to the emergency department at a public hospital, after falling at home and sustaining a hip fracture. Mr A had a complex medical history, including Type II diabetes, stroke, carotid artery disease and dementia.

18. On 16 Month 1, Mr A had surgery to repair the fracture. Following the surgery, he was assessed as being at high risk for falls and developing pressure sores. Mr A progressed well with rehabilitation and, on discharge on 1 Month 3, he was walking with a low walking frame, assisted by two people. He was assessed as requiring hospital-level care and transferred to a facility which is owned by Metlifecare Wairarapa Ltd (MLW).

Admission to MLW

19. On 1 Month 3, Mr A was admitted to MLW, accompanied by two of his daughters.

20. The admitting registered nurse noted that Mr A had two secondary diagnoses (delirium and a urinary tract infection) as well as dementia,[2] Type II insulin dependent diabetes and hypertension. The RN also noted that Mr A had impaired hearing and sight, and had suffered a stroke in 2001 but recovered well.

21. On 1 Month 3, Mr A's pressure ulcer risk was assessed using a Waterlow score[3] system and found to be high at 17. On 6 Month 3, this score was amended to 18. His falls risk was also assessed on 1 Month 3, using the Metlifecare risk assessment, and found to be medium at 9.

[2] Mr A's daughter, Mrs B, advised HDC that her father did not have dementia.
[3] A Waterlow score or scale gives an estimated risk for development of a pressure sore in a given patient. A total Waterlow score of >10 indicates risk for pressure area. A high risk score is >15. A very high risk exists at >20.

22. On 3 Month 3, visiting GP Dr F medically admitted Mr A to MLW. She checked his current medications and instructed the care staff to check his blood sugar levels on Monday and Thursday before breakfast and before giving him his insulin each evening. Dr F gave no further orders.

23. On 6 Month 3, Senior RN E completed a Lifestyle Care Plan for Mr A. The plan noted under the section on nutrition that Mr A was prone to dehydration and that staff were to ensure that he had fluids in front of him when he was sitting up, and that his intake be encouraged and monitored. The plan referred staff to Mr A's diabetic diet. In the section on mobility, RN E upgraded Mr A's falls risk to 10 (high). She instructed that he was to be toileted every two hours to prevent him going to the toilet himself. A mattress was to be positioned beside his bed at night, to cushion him if he got out of bed and fell. RN E noted, "Family have declined hip protectors and lap belt. They say it is [Mr A's] wish to maintain his independence and dignity and they accept as a family that he might fall." There were instructions to staff on the maintenance of his skin integrity, noting that he had fragile skin. In the nutrition section of the report, RN E instructed to "push fluids and monitor fluid intake" as Mr A was prone to dehydration. The plan also noted that Mr A was unable to use his arms to assist with his mobility as he had a "frozen" shoulder, and staff were to use the standing hoist or sling hoist when transferring him, if he was unable to weight-bear.

24. On 8 Month 3, Mr A's weight was 68.80kg.

25. Mr A's daughter, Mrs B,[4] Mr A's Case Manager and a Key Worker, Ms G, signed the Lifestyle Care Plan.

26. On 16 Month 3, the MLW diversional therapist completed an Activity Assessment for Mr A. She instructed staff to encourage him to walk and participate in the activities programme and socialise with other residents, noting that he required close supervision.

27. The nursing progress notes for Month 3 record that Mr A's relatives visited frequently, and that his dietary intake was satisfactory. Staff assisted Mr A with his hygiene cares and walking.

Falls — Month 3

28. Mr A fell a number of times in Month 3. Incident forms noted that he was found on the floor of his room as the result of unwitnessed falls on 6, 9, 14 and 17 (when he fell twice) Month 3, sustaining minor skin tears.

29. On 21 Month 3, Mr A's family met with MLW staff to discuss his falls. An RN noted the recommendations arising from the meeting:

[4] In 2000, Mr A gave Mrs B enduring power of attorney in relation to his personal care and welfare. To Mrs B's knowledge, this EPOA was never activated, as Mr A had all his "faculties" and was able to make his own decisions.

> "Family happy not to have lap belt. They would prefer to maintain his dignity as that is [Mr A's] own wishes. Continue to phone family with any changes. Continue to push and monitor fluids."

30. The RN recorded that Mr A's family stated that they would like Mr A to be taken out of his room more often. No other interventions were put in place. In response to my second provisional opinion, MLW Nurse Manager Ms D stated that staff did what they could to prevent Mr A's falls, including placing a bell on his bedside table and purchasing a "pressure mat to enable staff awareness when he attempted to walk".

Decline in health — Month 4

31. In Month 4, Mr A's appetite declined. On 10 Month 4, Mr A was vomiting and complaining of a sore back, and staff observed that one of his hands was swollen. Dr F was contacted and visited at 4.30pm. Dr F examined Mr A and thought he might have pylonephritis.[5] She prescribed Mr A a two-week course of the antibiotic Fluclox, and Maxolon to control his vomiting. Mr A's BSL was 7.8mmol/L.[6] Mr A's family was advised about his condition.

32. Dr F said that she did not record Mr A's temperature, pulse and blood pressure at this visit. She cannot recall the exact circumstances of her review of Mr A on this day, but told HDC that it is likely that she was provided with information about Mr A's current status by the duty RN, but omitted to record it.

33. During the next two weeks, Mr A was found to have three minor injuries — a torn thumbnail, a bleeding toe on his right foot, and a skin tear to his right elbow, and his low BSLs continued to cause concern. Mr A was given his prescribed antibiotics.

Falls — Month 4

34. Mr A sustained further unwitnessed falls on 7 and 19 Month 4, which were reported on incident forms. On each occasion, an RN checked Mr A for injuries.

Concerns about diabetes — Month 4/Month 5

35. Mr A's dietary intake remained variable during Month 4.

36. Around 25 Month 4, the diabetic nurse specialist, RN H, was contacted for advice about Mr A's concerning BSL test results. RN H recommended that Mr A be given 10 units of insulin before his evening meal, and that his morning insulin be increased by two units to 22 units, to be given before breakfast. Mr A's family were notified of the changes.

37. Dr F was advised about Mr A's diabetic status and approved the changes to his insulin. She did not visit but noted that the staff were to report Mr A's next BSL result to her.

[5] A kidney infection.
[6] BSL targets for people with Type II diabetes are 4mmol/L to 7mmol/L before meals.

38. On 26 Month 4, the nursing notes record that the duty RN spoke to RN H about Mr A's continuing concerning BSLs, and that it was agreed that Mr A be transferred to the public hospital by ambulance for further assessment and treatment of his diabetes.

39. On 1 Month 5, Mr A was discharged from the public hospital back to MLW. The hospital discharge summary noted that Mr A required urology outpatient follow-up and that he was to complete a five-day course of the antibiotic augmentin. There were no instructions regarding any changes to his insulin regimen.

40. At 6.45am on 13 Month 5, Mr A suddenly became limp when being transferred during morning hygiene cares. His BSL was low at 3.7mmol/L. Mr A's morning insulin was withheld, and he was given two glasses of orange juice and jellybeans. At 9.20am, Mr A's BSL was 6.7mmol/L. At 11.35am, his BSL had risen to 13.2mmol/L. Mr A was given his insulin at 11.40am. The nursing notes record:

> "V/b [visit by] son this afternoon who agreed that [Mr A] will require moulied meals and assistance with feeding whilst he is unwell. Meal changes to residents form given to [kitchen staff] to change [Mr A's] normal meals to moulied. … Also started fluid balance chart as he has an IDC [indwelling catheter] in & had a minimal output of 150ml this shift."

41. The following day, Mr A's daughter, Mrs B, visited and told staff that she did not want her father served moulied meals. The kitchen was advised accordingly.

Falls — Month 5

42. At 6.45am on 15 Month 5, Mr A had a further unwitnessed fall. This was discussed with Mr A's daughter when she visited later that day, and the RN again suggested that restraints would prevent Mr A hurting himself. However, Mr A's daughter confirmed that the family did not wish their father to be restrained. He had a further fall on 17 Month 5. There were no further instructions to staff about the management of Mr A's falls risk.

Pressure sore to heel — 20–24 Month 5

43. On 20 Month 5, the progress notes record that Mr A had developed a pressure area on his right heel. This was reported to the duty RN, who viewed the area. The progress notes do not record a plan to treat or monitor the pressure area at that time.

44. A wound assessment chart was not started for Mr A. RN E advised:

> "This was purely an RN error. RNs should know they need to do wound assessments as soon as noticed. It is standard procedure. I handed that over to RNs, discussed it at lots of RN meetings."

45. Ms D advised HDC that, on admission, Mr A was provided with a Cubro pressure-relieving mattress. She stated that when Mr A's physical health began to deteriorate and he developed pressure sores, she was informed by one of the RNs that he required an air mattress. Ms D said that she discussed the request for purchase of an air mattress with MLW management, but that the Regional Manager was not prepared to

sign off the purchase. In contrast, MLW advised that there is no evidence that Ms D followed the standard procedure for seeking approval for purchasing an air mattress.

46. RN E said, "[Mr A] had the best mattress MLW had, but it was not a proper oscillating mattress. We didn't have one of those." RN E said that MLW had only $100 mattress overlays, which were for patients with mild pressure areas. These mattresses were not suitable for serious pressure area situations.

47. RN E advised HDC that the RNs trialled Spenco protective booties for Mr A at this time. However, he was a high falls risk, as he frequently got out of bed unsupervised, and wearing the booties increased his falls risk.

48. On 22 Month 5, Mr A's Waterlow score (to estimate pressure area risk) was revised and increased to 28 (very high).

49. On 22 Month 5, RN E reviewed Mr A's care plan, noted that his pressure ulcer risk had been assessed as very high, and instructed staff to use a pressure reducing air mattress and a Spenco cushion when he was sitting in a chair. RN E also reviewed Mr A's nutritional needs, advised staff to ensure that he was "awake before breakfast arrives", but gave no new instructions. There is no indication that Mr A's family, or his key worker, were involved in the review of Mr A's Lifestyle Plan.

50. On 24 Month 5, the care staff reported that when the pressure ulcer on Mr A's left heel was redressed they noted that a section of the wound area had turned black. It was recorded in the progress notes that the RN was informed, but there was no further instruction recorded in the progress notes, or on a Wound Assessment and Treatment Tool form. At this time staff were also managing a thrush infection that Mr A had developed in his penis, which was red and swollen.

Fall and concern about possible fracture — 28 Month 5

51. At 7.40pm on 28 Month 5, Mr A had another unwitnessed fall. The progress notes record that when the RN checked him and palpated his hips, Mr A had noticeable pain, particularly in his left hip. The RN was concerned that Mr A might have a fracture and called an ambulance. The ambulance staff assessed Mr A but considered that there was no fracture. However, the MLW staff were advised to refer Mr A to the public hospital Emergency Department if they continued to have concerns about him.

Admission to the public hospital — 1–8 Month 6

52. Dr F was called to see Mr A at 7am on 1 Month 6 because of ongoing concerns about his penile infection. Dr F arranged to have Mr A transferred to the public hospital Emergency Department (ED) for treatment of paraphimosis.[7] Mr A's daughter, Mrs B, was advised of the transfer.

[7] Paraphimosis is an uncommon medical condition where the foreskin becomes trapped behind the glans penis.

53. Mr A's paraphimosis was unable to be reduced in the ED, so he was transferred to a medical ward and started on intravenous antibiotics. The ward staff recorded that Mr A had a dressing on a pressure sore on his right heel.

54. A medical review on 3 Month 6 described Mr A as suffering from "dehydration, chronic renal insufficiency, anaemia of chronic disease", as well as his current urinary problem — urosepsis.[8]

55. On 4 Month 6, the nursing notes record:

> "Wounds: Broken area to sacrum about the size of a 20 cent piece. Applied Comfeel.[9] Small reddened area on sacrum — Comfeel applied. Necrotic area on R heel, covered with Allevyn adhesive and Comfeel applied to L heel for protection."

56. The nursing staff continued to provide pressure area care to Mr A and administer the prescribed antibiotics. Mr A was discharged back to MLW on 8 Month 6, with instructions to MLW care staff regarding the dressing and monitoring of the pressure areas on his heel, shin and sacrum.

Hypoglycaemic episode — 8 Month 6

57. Mr A returned to MLW at 3pm on 8 Month 6. The progress notes record that he had pressure ulcers on his heel, shin and sacrum and, although his paraphimosis was not treated, he was treated for urosepsis.

58. At around 5.20pm on 8 Month 6, Mr A's daughter, Mrs C, visited and found her father unresponsive. She rang the call-bell and asked a caregiver to have a nurse assess Mr A, as she was concerned about his condition.

59. Soon afterwards, the duty RN, RN I, tested Mr A's BSL, which was 1.8mmol/L. RN I advised HDC that when she noted Mr A's BSL she immediately went to the nurses' fridge to get a Glucagon Pen,[10] but there was not one there. RN I said that because she was concerned about Mr A's condition she decided to give him a sweet drink and jellybeans (which he choked on). Mr A's BSL subsequently increased slightly to 2.4mmol/L. An ambulance was called, and Mr A was transferred back to the public hospital.

60. The MLW Blood Sugar & Insulin Chart records Mr A's BSLs for 8 Month 6 as:

"1700 [5pm]	1.8 No insulin given. 5 tsps sugar in hot water + 2 jelly beans
1720 [5.20pm]	2.4
1800 [6pm]	18 After IV glucose 10% paramedics

[8] A secondary infection that occurs when a urinary tract infection spreads to the bloodstream. It can be life-threatening if not treated immediately.
[9] A hydrocolloid dressing for moist wound healing.
[10] An emergency injection of glycagon used to treat hypoglycaemia.

2000 [8pm]	7.4 At [the public hospital]
2230 10.30pm]	4.6"

61. At 9.30pm, Mr A returned to MLW. The progress notes contain an instruction for staff[11] to monitor Mr A and to take his BSL twice during the night, and stop his gliclazide,[12] dipyridamole[13] and aspirin. Mr A's BSL was stable at 7.9mmol/L. The progress notes record that Mr A had a CT scan at the public hospital, which showed a chronic right subdural haemorrhage, 1cm in size. The records note, "D/w family — pt not for neurosurgical intervention + family happy with this."

62. Mr A was checked regularly throughout the night and given sips of water. His BSL was 7.3mmol/L at 3am, and 7.7mmol/L at 6am. Mr A complained of feeling cold during the night. His temperature was 35.5°C. The staff provided Mr A with another blanket and the heater was turned on.

63. On the morning of 9 Month 6, the duty RN telephoned RN H to discuss Mr A's BSLs. RN H advised the RN to withhold Mr A's insulin that morning. At 10am, his BSL was 10.4mmol/L. RN H asked to be contacted again at 1.30pm.

64. At 1.30pm, RN H was advised that Mr A's BSL was 16.6mmol/L. RN H instructed the RN to give Mr A eight units of protaphane insulin at 4.30pm and reassess the situation the next day. RN H advised the RN that she would inform the GP about Mr A, and asked the RN to telephone her again at 10am the following day.

65. On 10 Month 6, Dr F recorded in the Doctors Notes:

> "Back from hosp 2 days ago post admission for urosepsis. Has been back to ED with hypoglycaemia (documented at 1.8). Has not had any insulin this am & blood sugars up to 11.3 at 10.30am. Now 11.5. Will need a basal dose of insulin — possibly 8u bd [8 units twice daily] & then extra 4u. For bld sugar > 12. Will D/W [discuss with] [RN H]."

Pressure area management — Month 6

66. Mr A's progress notes for the afternoon of 11 Month 6 record, "When doing [Mr A's] care we noticed another pressure point developing on his left heel so RN informed and a Spenco boot was put on. No other concerns."

67. On 13 Month 6, Mr A's progress notes record, "[P]ressure sores on his bottom. RN has applied some dressing." Later that day, an RN recorded additional information about Mr A noting that the elastic holding his urinary catheter in place had chaffed his shin. The chaffed area was cleaned and covered with a Medlight dressing, padded with gauze and covered with a crêpe bandage. An incident form was completed and Mr A's family was advised of the skin tear.

[11] The author's signature is illegible.
[12] Gliclazide is an oral hypoglycaemic (anti-diabetic) drug.
[13] Dipyridamole is a medicine that inhibits clot formation.

68. Care staff continued to ensure that Mr A's Spenco boot was in position. However, on the evening of 17 Month 6, a caregiver washing him noted that he had a broken area of skin on his sacrum. A topical antiseptic, Betadine, was applied, and the area covered with an Allevyn[14] dressing. The RN on duty was advised, but a Wound Assessment and Treatment Tool form was not completed, and no treatment plan was written in the progress notes for the information of care staff.

69. The afternoon progress notes for 20 Month 6 recorded, "[Mr A's] heels checked. Both needed dressings which were attended to by the RN. Also left leg shin dressing was attended to." The night staff noted that Mr A's Spenco boots had to be replaced three times during the night, as when he turned over in bed the boots slipped up to his knees.

70. On 20 Month 6, a Wound Assessment and Treatment Tool form was completed, which described Mr A's right heel pressure ulcer to be "sloughy" with fragile surrounding skin. The treatment objectives at that time were to control bacterial infection and absorb exudate from the wound, by cleansing with normal saline and applying adhesive Allevyn, which was to be left in place for two to three days.

71. On 23 Month 6, the progress notes state, "Redressed [Mr A's] heels, followed the plan that is in the wound folder."

72. On 27 Month 6, the RN changing Mr A's sacral pressure ulcer dressing noted that he had a "small broken area approx 0.5cm on r) buttock". An Opsite dressing was applied to this area.

73. The Wound Progress Report sections of the Wound Assessment and Treatment Tools record the dressings to be applied, but do not evaluate the wounds' responses to treatment.

Monitoring of food and fluid intake — Month 6

74. The progress notes show that staff were recording Mr A's food and fluid intake, for example, the 10 Month 6 entry reads, "[Mr A] had a good breakfast this morning, had his porridge, kiwi fruit, glass of juice and cup of tea, refused the bread." A fluid balance chart was started, but was not filled in consistently. Mr A's BSLs were regularly checked and recorded.

75. On the morning of 28 Month 6, RN H was consulted about Mr A's low BSL (7.6mmol/L). RN H advised the RN responsible for Mr A that duty to retest his BSL at midday and call her back with the result. At midday Mr A's BSL had risen to 16mmol/L, and RN H told the RN to give him four units of protophane insulin.

76. On 29 Month 6 Mr A's family spoke to the duty RN, requesting that their father's fluid balance chart be completed daily and monitored. They also discussed providing Mr A with Complan, and the RN recorded that she would arrange this with the kitchen staff.

[14] Provides a moist healing environment and a bacterial barrier to encourage wound closure.

Weight loss — Month 6

77. There were no weights recorded for Mr A between 8 Month 3 and 29 Month 6. On 29 Month 6, Mr A weighed 55.7kg, having lost 13.1kg in the three months since his admission to MLW. Mr A was not referred for a dietitian assessment.

78. RN E stated that the residents' key worker care staff were responsible for weighing their assigned residents each month and reporting the result to the resident's case manager. RN E stated:

> "It was a battle to ensure weighs happened, all knew weighs should be done but not a good process. I put out a sheet with residents' names who needed to be weighed that month. I left notes in the communication book. I specifically highlighted key workers' names and asked them to weigh particular residents because it wasn't well done. [Mr A's] key worker, [Ms G], may have been on sick leave for some of that time. You would hope someone would pick up that weigh. I would have hoped that Case Managers should pick up weight not taking place."

79. Dr F reviewed Mr A on 10 Month 6, when staff were concerned about his diabetic status. Dr F advised the RNs to reduce Mr A's insulin to eight units at breakfast and tea-time and to give him an extra four units when his BSL was more than 12mmol/L.

80. RN E stated that the RN who accompanied Dr F when she reviewed Mr A should have discussed his weight loss and wound care. There is no evidence in the medical clinical notes to show that the RNs discussed Mr A's weight loss, frequency of falls, or Mr A's wounds with the doctor (until a severe wound was noted in Month 8).

81. Ms D stated that in early 2011, MLW purchased a computer programme to analyse monthly weights. Ms D was told that this programme would provide advice regarding resident weight loss and any supplementary nutrition required. Training in the programme was not completed because of trainer shortages. The night shift RN was responsible for programming residents' weights and reminding the nurses and caregivers when a resident's weight was due. Reminder notes were left on the notice board and/or communication book or discussed at staff meetings.

82. Ms D stated that if a significant weight loss was noted, it, as well as the need for nutritional supplements, would be discussed with the RNs as a team, and in some instances it would be brought to the doctor's attention. The RNs would ask the kitchen staff whether meals were being eaten. She said that the MLW kitchen stocked the nutritional supplement Complan, and sometimes milkshakes were requested for residents.

Falls — Month 6

83. Mr A had three unwitnessed falls in Month 6. At around 6.40pm on 25 Month 6, he was found on the floor by a member of the kitchen staff delivering his meal, and there was a further fall that day when he was in the care of an agency nurse. This latter fall was recorded by Ms D on an Incident form on 1 Month 7. Ms D queried whether Mr A had been assessed following this fall. There is no follow-up recorded. At 6.45pm on

27 Month 6, a caregiver found that Mr A had slipped out of his chair. The RN reviewed Mr A and did not detect any injuries.

Further deterioration and falls — Month 7

84. On 1 Month 7, Dr F replaced Mr A's urinary catheter, as the care staff had noticed swelling around his pubic area. The swelling was not painful.

85. On 3 Month 7, an Incident form was completed recording that Mr A had a "near miss" fall when he slipped out of his recliner chair. The duty RN discussed this with Mrs B and suggested that Mr A be provided with a "fall-out" chair, to prevent a recurrence. Mrs B agreed to a "fall-out" chair but did not agree to restraining her father in his chair with a lap-belt.

86. On 4 Month 7, Dr F replaced Mr A's urinary drainage catheter, as Mr A had disconnected it from the drainage tubing several times.

87. On 7 Month 7, Mr A was found on the floor beside his chair. The duty RN checked him for injuries, and assessed his temperature, pulse, blood pressure, respiration rate, oxygen saturation and BSL. He had no apparent injury, but his blood pressure was slightly low at 120/48mmHg.[15] Mr A's family was told about this fall.

88. Mr A's BSL on 7 Month 7 was high at 24.3mmol/L. The duty RN telephoned RN H to seek her advice. The duty RN recorded RN H's advice that Mr A's BSL would decrease overnight, but should be checked again in the morning.

89. Mr A's BSLs were monitored and his insulin given as prescribed. However, at 4.30pm on 9 Month 7, his BSL was 26.4mmol/L, after Mrs B gave him an icecream and a beer. When his BSL was checked at 8.30pm it was 31.2mmol/L, and Mr A was given an extra four units of protophane insulin as per the diabetic management plan.

90. On 11 Month 7, RN H was told about Mr A's high BSLs of 9 Month 7. She noted that Mr A's BSLs had returned to normal levels, and recommended that staff maintain Mr A's "quality of life by allowing him to have a few extras such as ice cream and a beer".

91. On 11 Month 7, staff noted that Mr A was unable to weight-bear. The progress notes instructed care staff to assess his ability to weight-bear on a day-to-day basis and use a sling or standing hoist, as necessary, to transfer Mr A between bed and chair.

92. On 12 Month 7, Mr A pulled out his catheter again. Dr F was informed but decided not to replace the catheter at this time. Mr A's BSL was low that morning, and the duty RN telephoned RN H for advice. RN H recommended that staff withhold Mr A's insulin, give him a sweet breakfast, retest his BSL at 10am and call her back after this. At 10am, Mr A's BSL had risen to 14.1mmol/L. RN H was notified and she told staff to give Mr A eight units of insulin.

[15] Normal adult blood pressure is 120/70mmHg.

93. Dr F telephoned MLW on 12 Month 7 to check on Mr A's status. She asked the staff to observe him for retention of urine. Dr F decided not to see Mr A for his routine three-monthly review, "in view of recent visits".

94. There was no change to Mr A's management until 21 Month 7, when the caregivers found that he had a pressure sore on his left buttock. The progress notes record that the area was dressed by the duty RN, who recorded that she completed a wound assessment form.

95. Ms D advised HDC that "one of the RNs" had the responsibility for monitoring the wound care folder to make sure that all wound assessments for any wounds or skin tears were completed and updated. Ms D said that she had to rely on the responsible RNs completing the appropriate documents, but some of the RNs had no understanding of the process and importance of completing care plans and assessments.

96. Mr A sustained unwitnessed falls on 8 and 12 Month 7. The falls were reported on incident forms, which noted that he sustained no injury in the falls.

97. On 24 Month 7, the progress notes state:

> "Dressings on heels renewed as per wound care plan & wounds malodorous. For reassessment/follow-up by Wound Nurse this week if possible. Wound on L) shin also renewed."

98. Mr A's daughter visited on 24 Month 7, and complained to staff that Mr A had been left in his recliner chair all day, and that he had a sore bottom.

Wound specialist assessment — 27 Month 7

99. On 27 Month 7, a wound care specialist nurse reviewed Mr A to assess the pressure areas on his right and left heels. She noted the condition of his heels as:

> "L) 3x4cm moist area. Grade III. Some necrotic tissue evident (soft & leathery) + slough present. Nil signs of infection. Little discomfort on contact. Little exudate. …
>
> R) heel (lateral aspect) 1.8 x 2.5 necrotic tissue in situ. Unable to debride. Tender to touch. Little exudate. Grade III P.A [pressure area]."

100. The specialist wound nurse documented her treatment plan for Mr A's heels, which was to continue for three to four weeks.

Admission to hospital — Month 8

101. Mr A's management remained unchanged until 8 Month 8, when his family was concerned that he was in noticeable pain. A note was made in the progress notes to contact Dr F to ask her to review Mr A and "discuss debriding [Mr A's] right heel to reduce the very offensive odour".

102. Dr F visited at 3.30pm on 9 Month 8 and recorded in the Doctors' Notes:

> "Asked to assess re gangrenous ulcers on both heels which are progressing & very foul smelling. Developing a pressure sore on his sacrum — also with a sore penis. Have D/W daughter [Mrs B] — who has POA. Have agreed not to treat actively as we will not be able to reverse the gangrene & he is not a fit candidate for amputation — nor do family want him put through this.
>
> Plan — stop all regular meds apart from insulin. Give morphine 10mg bd & elixir prn [as required]. Use metronidazole[16] tablets to wound to control smell."

103. At 6pm, Dr F telephoned MLW and advised staff that she had discussed Mr A's management with a colleague, who advised that his BSL and insulin should be stopped. Dr F said that she had spoken to the family, who agreed that Mr A was not to be actively treated. Sadly, Mr A died at around midnight on 12 Month 8.

Dr F

104. Dr F advised HDC:

> "I have thought a lot about how the situation arose that led to the circumstances around [Mr A's] death. As his GP I feel a certain amount of responsibility for his suffering. I have concluded that the main problem was a lack of communication. We are so reliant on the nursing staff to tell us their concerns about a problem a patient has. At no time did rest home staff ask me to review [Mr A's] pressure sores, or express any concerns about these until I was asked to visit on 9 [Month 8]. The involvement of the Wound Care nurse seemed to have been their main way of dealing with the pressure sores. Generally when district nurses, including the wound care nurse, are involved in the management of patient's wounds, they will do a wound swab and request antibiotic treatment of the GP, if they think the wound is infected. This also did not happen. … Diabetic foot ulcers in the elderly can progress to gangrene very rapidly.
>
> … [T]he provision of medical care to patients at Metlife has changed dramatically since [Mr A's] demise, and this is in no small part a result of the problems encountered with his care. We now have a system whereby each rest home has a designated doctor who does a weekly clinic at the rest home. This means that the nursing staff and the doctor get to know each other and can work together to provide a better level of care. We are able to follow up patients every week if needed, at no extra cost to the rest home, and routine reviews of patients are undertaken regardless of how many times they have been seen in the previous 3 months."

Ms D

105. Ms D, who is a registered mental health nurse (overseas registration), commenced employment as Nurse Manager at MLW in August 2007. At the time of these events,

[16] An antibiotic (also known as Flagyl).

Ms D had a condition on her scope of practice that she was to practise only in mental health nursing.[17]

106. The MLW position description requires the Nurse Manager to demonstrate leadership by personally maintaining a high standard of clinical care and knowledge, adhering to all company policies and procedures and ensuring that all care staff are trained, skilled and supported in delivery of high quality care. The role's key tasks/accountabilities were detailed under the headings: clinical leadership, occupancy management, risk management, financial, human resources, quality, professional standards and development, and health and safety.

107. MLW advised HDC that it provides its nurse managers with a three-day staff orientation programme, which provides a checklist for areas for familiarisation under the role's key tasks/accountabilities. The orientation checklist Ms D completed shows that she was orientated to areas of MLW such as organisational structure and communication, finance and business management, and health and safety policy.

108. Ms D advised HDC that her role as Nurse Manager at MLW included planning and presenting the yearly care facility and staff budgets, completing all staff appraisals (except for kitchen and gardening staff) by June each year, and developing in-service training schedules. She was also responsible for facilitating monthly meetings with senior registered nurses, caregivers, diversional therapists and residents, and collating the minutes as required, and reporting on quality improvement and hazard review/evaluation. The Nurse Manager is also responsible for distributing new and changed policies and procedures.

109. Ms D also advised that initially, MLW expected her to cover the RNs' lunch breaks. However, she said that this requirement was "reversed" while MLW contacted the Nursing Council about changes to her scope of practice. She said that she was not allowed any direct clinical contact with the residents. She stated, "This proved a very difficult time for me, as I believed the RNs lost confidence in my ability to manage the rosters, and this impacted on my relationship with them."

110. Ms D stated:

> "My role within Metlifecare was to support and manage the clinical team and not to provide direct clinical care. Much of the documentation needed for my role, and the supervision of staff was completed in my own time so that I could have a level of assurance the team I led were supported and that management expectations of my role could be fulfilled. …
>
> I was given the orientation package to complete myself due to the previous manager's unavailability. This was an unsupported task. I was given some orientation by [the village manager] around budgets and financial aspects to the

[17] Ms D undertook training in gerontology and, on 2 Month12, her scope of practice was extended to include aged care settings.

> role. … There was some support from the previous senior registered nurse who stated she had very little experience in the nurse manager role."

111. Ms D was supported in her role by RN E, who was responsible for the oversight of clinical care. On 13 July 2010, Ms D attended a Clinical Management Team teleconference, and stated that she was concerned about the amount of work she and RN E were expected to achieve without support. It was recorded in the meeting minutes that Ms D stated, "[I]f the work levels are going to increase, we feel we won't cope."

112. Ms D advised HDC that she introduced a quality improvement initiative to address the issues of caregivers not having time to read care plans, and RNs not updating and amending care plans. This included RNs reading and discussing the care plans with caregivers on duty each evening and updating them where appropriate. Ms D advised HDC:

> "This appeared to work well at first, documentation and feedback from the RNs and caregivers proved this to be a very worthwhile exercise. However, the task became less and less effective with the increased workload of the RNs and caregivers, even though reminders were left on the notice board and in the communication book.
>
> I voiced on several occasions the risks that some of the RNs had difficulties with documentation, clinical assessment skills, and the general management of their shift including the allocation of the caregivers. …
>
> My performance appraisal clearly outlines comments made throughout concerning my workload and registered nurse risks to the Company. This was never followed up."

113. Ms D advised that the pressure placed on her because of her excessive workload led to her having to take sick leave in Month 6. Ms D said that at around the time of Mr A's death, she reduced her hours in order to try to manage her stress, working more accurately the hours she was employed to work.

RN E

114. RN E advised HDC that she commenced employment at MLW in January 2007 as a casual employee and, when the previous senior RN resigned in August 2009, accepted a permanent part-time position as the senior RN, a 16-hour a week position. Her orientation to MLW was via a self-directed learning package, which was "just a tick list, one that everybody does". RN E said that the learning package was dated eight months after she started.

115. RN E stated that the RN responsibilities were detailed in the position description, included filling vacant shifts for RNs and caregivers. The senior RN was also responsible for following up on incident/accident forms and investigating and implementing any quality improvements arising with the Nurse Manager. RN E said that she was also responsible for ensuring that admission processes for new residents

were completed, and that assigned RNs completed assessments and initial care plans for all residents. Other responsibilities included: organising family meetings, monthly audits, arranging GP three-monthly visits to residents, checking and ordering stock, interviewing and checking references for caregivers, monitoring orientation, and assisting the Nurse Manager with staff appraisals.

116. RN E stated:

> "Metlifecares RNs over this period included three new grads, all employed around the [Month 4] period. There was only one RN who worked full time. Some RNs lack of understanding of the importance of documentation and treating the care plan as a living document to add to or discontinue information as condition changed was not understood."

117. RN E said that RNs were assigned as case managers to new residents on admission. As the case manager, the RN was responsible for completing the care plans, three-monthly reviews, and on-going documentation on the care plan as the resident's condition changed. She said that RNs reported that they did not have sufficient time to complete these tasks. As some of the RNs were unable to use MLW's computer system, she spent a great deal of her time checking resident charts, completing three-monthly reviews, and ensuring that paperwork such as a resident's resuscitation status was completed. RN E stated that she would remind RNs when resident reviews were due. She said that a system was introduced so that RNs could spend time on the afternoon shift reading through resident files with caregivers and reviewing the care as a group. However, time constraints prevented this system from continuing.

118. RN E stated:

> "The responsibility at Metlifecare and the huge work load to be managed in two days was impossible. It did not allow consistency and the ability to know what was happening on the floor. I had felt unsafe for some time. I verbally expressed my concerns regarding risks and my safety to [the Village Manager] when I informed him I had accepted a new position.
>
> I strongly believe there weren't enough RN hours at Metlifecare Wairarapa. On PM shifts, and weekends the RNs were the sole charge. If there was an emergency in the Village or apartments (75 units) it was the RNs responsibility to attend, as well as be responsible for the Rest Home and Hospital.
>
> The Nurse Manager and I both felt the clinical management structure at Metlifecare required looking at by support office. The Nurse Manager's RN training was mental health. Her hours were calculated by support office into RN hours to run the facility safely. The Nurse Manager and I had discussed this area of concern on a number of occasions. We strongly agreed that more RN hours were required."

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119. MLW advised HDC that the Nurse Manager and Senior RN are responsible for 43 hospital and rest home level residents. Each resident has an assigned key worker and case manager. Each RN is responsible for five to six rest home/hospital residents, supported by caregivers. The RN is responsible for ensuring that the progress notes are completed for hospital patients over a 24-hour or shift-by-shift basis. Weighing individual residents is the responsibility of the shift caregiver, and the frequency of weighing is specified in MLW policy.

120. MLW staff had position descriptions. MLW also provided staff with guidelines, policies and procedures in the care of the elderly. MLW's "Clinical Guidelines for Residential Care Facilities" covers topics such as, but not limited to: admission procedures, activities for daily living, skin integrity, and resident handling. There are also specific policies regarding pain management, falls management, nutrition and diet and wound management.

121. MLW's policy/procedure for Case Management states that case management is a managed approach to care which utilises the Lifestyle Plan. The principle underlying care planning is a relationship of partnership, clinical management and/or advocacy. Nursing interventions are based on evidence based practice, and the evaluation of effectiveness of selected interventions and resident outcomes are to be conducted three monthly.

122. MLW's "Clinical Guidelines for Residential Care Facilities" guide for care staff on the management of skin integrity advises: "Aids for comfort and prevention of pressure areas do not replace the need to be vigilant with regular two (2) hourly care." There is a detailed procedure to guide care staff carrying out two-hourly pressure area care.

123. MLW's Nutrition and Diet policy states: "Maintaining good nutrition and the intake of adequate amounts of fluid is very important for tissue maintenance and repair." The policy notes that protein intake is important for healing and to fight infection. The Falls Management policy states: "All residents will be assessed for risk of falls and have a Falls Management Plan documented where appropriate." The Wound Management policy and procedure states that a Wound Assessment and Treatment tool will be used initially and throughout treatment to assist in wound healing.

124. MLW's Lifestyle Plan policy states that the Lifestyle Plan Interim 21 Days must be developed within 24 hours of the resident's admission, and is a "transparent partnership process developed collaboratively with the resident/family/advocate and healthcare providers". The policy states that the Lifestyle Plan must be written in such a way that care providers can easily interpret the resident/family's everyday choices while reflecting the requirements of health professionals. The plans are to be evaluated when the resident's needs change, no less than once every three to six months. The evaluation includes input from the resident, multidisciplinary team, and the resident's family or advocate.

125. An internal investigation into the complaint about the care provided to Mr A found that MLW staff failed to:

- maintain an appropriate level of communication with Mr A's family —the daily visits by the family and conversations led to an assumption of communication;
- document a care plan specific to Mr A's weight loss;
- supply the appropriate mattress in a timely manner; and
- consistently document the progression of Mr A's condition in relation to his wounds.

126. MLW advised HDC that the RNs at MLW have reflected on the standard of care provided to Mr A, and the learning arising from this case. Over 2011/2012, a programme of education and training occurred for all staff at MLW, which focused specifically on the areas identified in the complaint, communication, prevention and management of pressure areas and the care of wounds, liaison with the relevant clinical experts, and palliative and end of life care. MLW stated:

> "The procedure for wound care has not changed in terms of policy and documentation since the complaint, however the follow through and management of all pressure area, assessment of wounds, expert advice and individual care plans has improved. All three month resident reviews of Waterlow scores (pressure area scores) are updated and discussed at the weekly clinical meetings. These are also discussed weekly (more frequently if required) with the doctor; clinical nurse specialist should this need to occur. …
>
> We have changed our systems and facility culture to reflect the care we provide with the aim to prevent harm and provide a more resident centred care approach that will reduce the variability in the quality of care we provide to residents and family members."

Response to provisional opinion

127. MLW, RN E, Ms D, RN I and Mrs B were provided with relevant sections of my provisional opinion for comment. Relevant responses have been incorporated above. In addition, MLW's submissions are outlined below.

128. MLW submitted that it had the necessary systems, policies and procedures in place as required by the New Zealand Health and Disability Sector Standards, including a quality and risk management system. In support of this submission, MLW stated that the results of an independent certification audit carried out in 2009 and a surveillance audit[18] carried out one month before Mr A's admission concluded that MLW's services were compliant with the relevant New Zealand Sector Standards. It stated

[18] MLW described the surveillance audit as an unannounced "spot-check" to check progress has been made on outstanding areas identified by the 2009 audit, and that standards have not slipped. The audit included reviews of client and staff records, and interviews with management, staff and consumers.

that MLW has a strong record of compliance with the relevant New Zealand Standards.

129. MLW also submitted that it had sufficient staff levels and mix to reasonably ensure that its staff could meet the health and personal needs of all residents at all times. In support of this submission, MLW stated that the 2009 and 2010 audits confirmed compliance with the Age-Related Residential Care Services Agreement (ARRC) requirements and the Ministry of Health's recommended staff levels and skill mix. MLW further noted that it employed staff over and above those requirements, and that occupancy had fallen during the time of Mr A's residency. MLW referred to its system for recording staff members' actual hours worked, which showed that neither Ms D nor RN E worked excessive hours between 22 Month 2 and 29 Month 8.[19] MLW stated that it therefore rejects Ms D's and RN E's evidence that they were overworked and that MLW was understaffed.

130. MLW stated that Ms D's role was to support and manage the clinical team, but not to provide clinical supervision. It submitted that it took all reasonable steps to ensure there were sufficient systems and procedures to allow Ms D to support staff and provide quality of care. It stated that Ms D was capable in her role, the DHB had approved of her appointment as Nurse Manager, and the 2010 audit recorded that she was suitably qualified and experienced for the role.

131. MLW stated that RN E's role was to fulfil the part of Ms D's role that Ms D was unable to fulfil because of the restriction on her scope of practice (ie, clinical supervision). It submitted that it took all reasonable steps to ensure there were sufficient systems and procedures to allow RN E to support staff and provide quality of care. MLW submitted that RN E never complained about excessive workload, and that the conclusions of the 2009 and 2010 audits regarding staff levels and mix (detailed above) support MLW's submission that she was sufficiently supported to supervise clinical practice.

132. MLW submitted that "[t]his simply is not a situation where MLW has failed to meet its obligations in relation to service delivery — it is a case of unfortunate, but at times, inevitable, human error". In particular, MLW submitted that:

- there were adequate systems in place to ensure that residents and their family members could access information about a resident. The 2009 and 2010 audits indicated that residents and families felt satisfied with communication with staff. MLW also submitted that there was evidence in Mr A's case that staff were communicating adequately with Mr A's family. For example, staff complied with the family's wishes that Mr A not be restrained. MLW submitted that the daily visits by, and conversations with, Mr A's family led to an assumption of communication;

[19] In response to my provisional opinion, Ms D advised that this system was introduced in Month4, was new at the time of Mr A's death, and reflects only the average hours she worked up until that point.

- the 2010 audit notes that the general practitioner stated that there was very good communication between all staff members;

- there were adequate systems in place to ensure staff recorded residents' weights once a month. It was the shift caregiver's responsibility to weigh residents, and RN E was responsible for auditing the residents' weights to ensure monthly weighing occurred. Despite a review of Mr A's Lifestyle Plan in Month 5, evidently RN E did not notice that Mr A's weight had not been recorded monthly. MLW considered that this was an individual, not systemic, failure; and

- there were adequate systems in place to ensure staff provided services relating to wound care with reasonable care and skill. In support of this submission, MLW noted the conclusions of the 2009 and 2010 audits, including that MLW was compliant with good practice standards and legislative requirements. MLW noted RN E's acknowledgement that the failure to start a wound assessment was "purely RN error" and submitted that this was an individual, not systemic, failure.

133. MLW submitted that it took reasonable steps to ensure there was adequate clinical oversight of their staff. In addition to the points noted above, MLW noted the following:

- Any deficiencies in service delivery are identified through monthly data analysis, and quality improvements are implemented.
- Reviews of documents occur at a monthly nurse managers' meeting.
- Education sessions are held following the publication of new or reviewed policies.
- An RN oversees all care provision.
- There was a comprehensive range of internal audits that monitored performance. The internal audits are conducted according to the calendar, and include care plans and medication management. Data is collected, analysed and evaluated and corrective action is taken as necessary, usually by the Senior RN (ie, RN E). The data is monitored by the national clinical manager and benchmarked across other service sites.
- MLW senior management provided monthly on-site visits by the MLW Operations Manager, support from the Village Manager, monthly CMT meetings (nurse managers and care managers), on-site visits from the Director of Nursing every three to four months, and regular telephone contact with the Director of Nursing and other senior clinical managers at least weekly.

134. MLW submitted that it was only obligated to take such steps as were reasonably practicable to prevent its employees from doing or omitting the errors identified in my provisional opinion, and that it reasonably did so. MLW stated that it does not logically or factually follow that MLW is at fault.

Response to second opinion

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135. MLW accepts that "some MLW employees failed in some specific areas to provide a reasonable level of care and skill to [Mr A]". However, it submitted that "it is not reasonable to conclude that these specific failings are indicative of a general or widespread failure by staff".

136. MLW advised that it does not wish to formally challenge the Deputy Commissioner's conclusion that there was a breach of Right 4(1). However, it does not consider that the breach was the result of wider system or organisational issues, as it had adequate policies and procedures in place. MLW submitted that "[t]he evidence shows that MLW staff have been independently assessed and continuously met or exceeded New Zealand Standards with such criteria for nearly a decade, including in the month immediately prior to Mr A's admission".

137. In relation to Ms D's appointment, MLW submitted:

> "[Ms D] was appointed to the role of Nurse Manager with the full knowledge and approval of the DHB and Nursing Council New Zealand. All agreed her appointment was appropriate at the time and, in particular, the DHB understood and agreed that [Ms D] was to be supported with a clinical RN lead, which she was."

Ms D

138. Ms D stated that the Operational Manager "mainly remained in the village office, working with the Village Manager" during her 2–3 monthly visits. Ms D advised that she also had monthly telephone conferences with the MLW Nursing Director during which she would be able to discuss any concerns.

139. Ms D also stated:

> "Whilst I feel that I did let [Mr A] and his family down, I do not believe 'my care' fell below an acceptable standard. I have always taken great pride in my work, doing the best with what resources I have, working to the best of my ability. Working at [MLW] had its daily challenges for me feeling torn between expectations from management versus the difficulties I encountered by the registered nurses on site. I believe that I made good sound quality improvements as evidenced by the external audit results, complimentary letters received from [MLW] senior management family members, external agencies and planning and funding. …"

Relevant standards

140. The Nursing Council of New Zealand's "Competencies for registered nurse scope of practice", approved by the Nursing Council in December 2007, states:

> "**Competency 1.3**
>
> Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others.
>
> …
>
> **Indicator:** Makes appropriate decisions when assigning care, delegating activities and providing direction for enrolled nurses and others.
> **Indicator:** Understands accountability for directing, monitoring and evaluating nursing care.
>
> **Competency 2.2**
>
> Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings.
>
> **Indicator:** Undertakes assessment in an organised and systematic way.
> **Indicator:** Uses suitable assessment tools and methods to collect data.
> **Indicator:** Applies relevant research to underpin nursing assessment."

Opinion — Introduction

141. Mr A was 89 years of age and suffered from multiple medical problems. He was admitted to MLW on 1 Month 3 for long-term, hospital-level care. He was a resident at MLW for just over five months. During that time, several aspects of his care fell below an appropriate standard, as discussed below.

Weight/hydration monitoring

142. Metlifecare Ltd's Nutrition and Diet policy states: "Maintaining good nutrition and the intake of adequate amounts of fluid is very important for tissue maintenance and repair." The policy notes that protein intake is important for healing, to fight infection, and for wound management.

143. It was the shift caregiver's responsibility to weigh individual patients, and this process was monitored by RN E. However, staff failed to monitor Mr A's food intake and respond appropriately when significant weight loss was identified. When Mr A was admitted to MLW on 1 Month 3, his weight was 68.8kg. He was next weighed on 29 Month 6, and had lost 13.1kg (17.5% of his bodyweight). Mr A's Lifestyle Plan was reviewed by RN E in Month 5 but his weight loss and lack of weight recordings were not identified.

144. My independent nursing expert advisor, Mrs Jan Grant, advised that it was particularly important for Mr A, a diabetic, to have been weighed each month. Mrs Grant advised that any weight loss of greater than 5% over a six-month period should be investigated.

145. There were no written instructions to staff in Mr A's Initial Care Plan, Lifestyle Plan or the progress notes about the frequency with which Mr A was to be weighed. There was also no written instruction to staff in the progress notes to monitor his food and fluid (although there were some directions regarding fluid intake in the Lifestyle Plan). Mrs Grant said that a Food Recall chart would have assisted staff to assess the amount and type of his food intake accurately. When Mr A's concerning weight loss was identified in Month 6, there were no proactive measures taken, such as a referral to a dietitian or informing Mr A's GP about his weight loss.

146. In Month 5, fluid balance recording charts were started to monitor Mr A's fluid intake, but the charts did not record his fluid input and output consistently. As Mrs Grant observed, without Mr A's output being recorded, it is difficult to obtain an accurate picture of his hydration status.

Wound management

147. Mr A's wound management was inconsistent. His Initial Care Plan, completed on admission, identified him as having fragile skin and being at high risk of developing pressure ulcers. His risk increased to very high in Month 5.

148. Mr A's Lifestyle Plan instructed staff to observe his skin integrity on shower days, report any concerns such as abrasions, reddened areas or tears, and apply moisturisers to his skin after a shower. Despite those precautions, between 20 Month 5 and 13 Month 6, Mr A's skin integrity deteriorated. The progress notes show that Mr A had wounds or broken skin on both heels, and on his sacrum, bottom and shin.

149. Staff dressed Mr A's wounds and trialled Spenco protective booties. In Month 5, Mr A was provided with a pressure-reducing mattress and a Spenco pressure-relieving cushion for his chair. In Month 7, specialist nursing advice was sought for Mr A's wounds and, on 11 Month 8, an air mattress was introduced.

150. However, Mr A's Wound Care chart and Lifestyle Plan were not updated consistently to show the severity of the wounds and the nursing interventions required for pressure area care. A Wound Assessment Tool, required by MLW's Wound Management policy, was not completed for Mr A's right heel wound until 20 Month 6, when it was first noticed on 20 Month 5. Wound Assessment Tools for Mr A's sacrum and shin wounds were only partially completed. There is no record of other Wound Assessment Tools being completed for Mr A.

151. There is also insufficient evidence that Mr A's wound care was evaluated. No changes were made to Mr A's treatment plan after he returned to MLW from the public hospital on 8 Month 6 with instructions from hospital staff about managing his wounds. The Wound Progress Reports record the dressings to be applied but do not evaluate the response of the wounds to treatment. Furthermore, although there were

instructions about general wound prevention in Mr A's care plan, the RNs gave few written instructions to care staff about how to manage the wounds that subsequently developed. A separate wound folder was held in the Registered Nurses' treatment room, which identified the patients receiving wound care, but did not provide information to care staff about the assessment and management of the patients' wounds. Mrs Grant stated that a patient's wound care should be treated as an individual treatment, and a separate assessment form and ongoing evaluation should be kept in the patient's clinical notes.

152. Mrs Grant advised that a more proactive approach would have ensured that an air mattress was used earlier. I agree that the management of Mr A's multiple wounds was deficient.

Management of falls

153. MLW's Falls Management policy states: "All residents will be assessed for risk of falls and have a Falls Management Plan documented where appropriate."

154. Mr A's falls risk was reviewed three times while he was at MLW. On admission, he was identified as being at medium risk of falls. His risk was upgraded to high a few days later. To counter that risk, MLW provided Mr A with a "low, low bed" and positioned a mattress beside his bed. However, there is no evidence that consideration was given to obtaining advice from allied health professionals on the management of Mr A's falls risk, or that a Falls Management Plan was developed.

Communication between staff

155. Mr A had complex needs. He fell frequently, his BSLs were unstable, and he developed several wounds that were difficult to treat and manage. Mr A was visited 12 times by a doctor between Month 3 and Month 8. However, there is no evidence in the medical clinical notes to show that the RNs discussed Mr A's weight loss, frequency of falls, or Mr A's wounds with the doctor (until a severe wound was noted in Month 8).

156. Mrs Grant advised that the RNs should have sought medical advice for Mr A's falls, weight loss and wound care. I agree. As noted in a previous Opinion:[20]

> "Good aged residential care is dependent on services being provided with reasonable care and skill. It requires the co-operation of everyone involved, and effective communication — between health professionals and with residents and families."

Care planning

157. The MLW Lifestyle Plan policy was not followed for Mr A in relation to his wound care, weight loss and communication with his family. The policy required Lifestyle Plans to be developed in consultation with the patient, family or patient advocate and multidisciplinary team. The policy also required the Lifestyle Plan to be written in

[20] Opinion 09HDC01783, page 24.

such a way that care providers can easily interpret the plan of care. A resident's Lifestyle Plan was to be evaluated when the resident's needs changed, no less than once every three to six months. The evaluation was to include input from the resident, multidisciplinary team, and the resident's family or advocate.

158. On 6 Month 3, RN E completed a Lifestyle Plan for Mr A. The plan noted Mr A's baseline recordings of weight, blood pressure and pulse rate, and his daily living requirements such as nutrition and hygiene needs. The plan also noted Mr A's high falls risk, his family's wishes regarding management of his falls, instructions for maintaining his skin integrity, and instructions to "push fluids and monitor fluid intake" to avoid dehydration.

159. On 22 Month 5, RN E reviewed Mr A's Lifestyle Plan. She recorded that he was now a very high pressure ulcer risk, and instructed staff to use a pressure-reducing air mattress and a Spenco cushion. RN E also reviewed Mr A's nutritional needs, advising staff to ensure that he was "awake before breakfast arrives", but she gave no other instructions.

160. The directions to staff relating to Mr A's increased care needs in the amended Lifestyle Plan are sparse. As noted above, the plan does not record all of his wounds (or, at the very most, did not include them until Month 6) and the clinical intervention required, and did not fully document what was expected of the RNs and care assistants involved in his care, such as two-hourly position changes. Although the Lifestyle Plan notes, under the Nutrition section, that Mr A was prone to dehydration and required additional fluids and intake monitored, this was not recorded in the daily progress notes, which are completed by the RNs and care assistants and form the major part of the reviews of care provided to Mr A. Furthermore, contrary to the policy, there is no indication that Mr A, his family, or any other health professionals were involved in the Month 5 review of the Lifestyle Plan.

Documentation

161. It appears that staff at MLW lacked understanding of the importance of documentation. As noted in an earlier HDC opinion relating to the provision of residential care:[21]

> "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."

162. The care provided to Mr A, and evaluations of that care, were not documented consistently in the progress notes. Many of the entries in the progress notes were documented by care assistants, and Mrs Grant advised that although there are instances when this is acceptable, entries for patients like Mr A should be checked and counter-signed by an RN.

[21] Opinion 08HDC17309, page 24.

163. Mrs Grant advised that staff recorded Mr A's food intake in subjective terms such as, "had a good breakfast", which gave no real indication of his actual intake. There were also shifts and days when nothing was written in the progress notes about the care provided to Mr A. Mrs Grant advised that while it is acceptable to miss some shift or daily entries in the progress notes when a patient is stable, it would be general practice, when a patient is unwell and/or has multiple medical problems, for staff to document the patient's status and the care provided at each shift. Mr A came into this category, as he required constant monitoring of his nutritional needs, BSLs, mobility and wound care.

Opinion: Adverse comment — RN E

164. In August 2009, RN E was employed in a permanent part-time position as Senior RN at MLW, 16 hours per week. Her responsibilities as Senior RN were to ensure that admission processes for new residents were completed, and that the RNs completed assessments and initial care plans for their assigned residents. Other responsibilities included: monitoring staff orientation, monthly audits, arranging GP three-monthly visits to residents, checking and ordering stock, and organising family meetings. The Senior RN was also responsible for interviewing and checking references for caregivers, and assisting the Nurse Manager to follow up on incident/accident forms, investigate and implement quality improvements, and assist with staff appraisals. RN E said she was also expected to work shifts if there were RN and caregiver shortages.

165. RN E advised HDC that she spent a great deal of time checking patient charts, completing three-monthly reviews and ensuring documents, such as a patient's resuscitation status, were completed when the RNs reported that they did not have sufficient time to complete their assigned patients' documentation or were unfamiliar with the MLW's computer system. RN E stated that a lack of registered nurses and staff difficulties in 2010/2011 impacted on her ability to fulfil her role. In 2010, Ms D raised concerns about her and RN E's workload, and a lack of support. There is no evidence that RN E herself communicated any concerns about her workload to management.

166. RN E, as the senior RN at MLW, was responsible for ensuring that Mr A received adequate care and support. As set out above, I am satisfied that Mr A's weight loss, hydration and pressure ulcers were not assessed adequately, and that appropriate care plans were not put in place. In a recent opinion,[22] I noted:

> "In light of widespread and common failures, attention turns to the person responsible for ensuring the RNs, EN and HCAs were complying with policies and job descriptions, and for taking remedial action where it was not."

167. However, my independent expert nurse advisor, Mrs Grant, advised that the workload for RN E's responsibilities exceeded the allocated hours. In my view, RN E's

[22] Opinion 09HDC01974, page 30.

workload was excessive, given she was employed for only 16 hours per week. Furthermore, there was a lack of continuity and fragmentation of the clinical management systems in place at MLW in 2010/2011 (discussed further below), which I consider affected RN E's ability to monitor the quality of the care provided. It would therefore be unreasonable, in these circumstances, to find RN E in breach of the Code.

Opinion: Adverse comment — Ms D

168. Ms D was appointed to the position of Nurse Manager at MLW in August 2007. As the Nurse Manager at MLW, Ms D was responsible for supporting and managing the clinical team. The Nurse Manager job description stated that one of the key accountabilities for the role was demonstrating leadership by personally maintaining a high standard of clinical care and knowledge.

169. Ms D qualified as a mental health nurse overseas in 1979, and her New Zealand practising certificate limited her to clinical practice in mental health only during Mr A's stay at MLW. She undertook further training and, on 2 Month 12, her scope of practice was extended to the aged care setting.

170. Ms D's role involved planning and presenting the yearly care facility and staff budgets, completing the annual staff appraisals (except for kitchen and gardening staff), and developing in-service training schedules. She was responsible for quality improvement and hazard review/evaluation, distributing new and changed policies and procedures, and facilitating and following up on the monthly meetings with senior registered nurses, care assistants, diversional therapists and residents.

171. Ms D's role included clinical practice. Ms D advised HDC that she was expected to manage the RNs' performance and perform clinical tasks, such as covering the RNs for lunch breaks. However, Ms D said that, if she had performed these tasks, she would have been practising outside the scope of her practice, so the requirement for her to provide RN cover was "reversed" while MLW contacted the Nursing Council to clarify Ms D's scope of practice. Ms D said she never provided direct clinical care to the residents at MLW. MLW advised that Ms D was supported in her role by RN E to assist in fulfilling the clinical requirements of Ms D's role.

172. Four months prior to Mr A's admission, Ms D raised her concerns about her workload and that of the senior RN, RN E, and the lack of support, at a Clinical Management Team meeting. Ms D later stated that she was having difficulties with some RNs "with their own agendas", and that she felt like the "ambulance at the bottom of the cliff" because of her workload. She said there were occasions when she worked as a care assistant at MLW to cover staff shortages. Twice Ms D raised concerns about her workload in her performance appraisal, and twice she had to take sick leave because she was so stressed. It appears that Ms D's specific concerns about staffing and workload were not addressed by MLW management.

173. Ms D stated that she was aware that some staff were not reading, updating and amending care plans, and introduced a quality improvement initiative to address these matters, which was initially successful. However, as workloads increased, the RNs lost confidence in Ms D's ability to manage, and this had an impact on her relationship with them and the improvements she tried to introduce.

174. Nevertheless, Ms D had overall responsibility for supporting and managing the clinical team to ensure that a quality service was delivered to patients. In this regard, Ms D failed Mr A.

175. Mrs Grant advised that Ms D's workload was excessive. Mrs Grant stated:

> "It is my view that [Ms D] cannot be held responsible for any clinical decisions that were inappropriate as it was not within her scope of practice as defined by the nursing council which consigned her scope of practice to mental health until [Month 12] hence she was unable to supervise and direct care in an Aged Care setting. Evidence is available to show that senior staff knew and understood the limitations of her practice."

176. I agree with Mrs Grant that Ms D was working in an environment that did not have adequate systems in place to ensure that she was able to support her staff to provide quality care, and that it would be unreasonable to hold her accountable for the failures of care. Therefore, although Ms D's care fell below an acceptable standard, it did not amount to a breach of the Code.

Opinion: Breach — Metlifecare Wairapapa Ltd

177. There were repeated failures by multiple staff at MLW to provide services to Mr A with reasonable care and skill. There were widespread failures to assess, monitor and evaluate his condition adequately, which were compounded by poor clinical oversight. I consider that MLW must take responsibility for the extent of such failures.

Clinical oversight

178. At the time of these events, MLW Nurse Manager Ms D was a registered mental health nurse. The Nurse Manager's role at MLW is usually to support and manage the clinical team and to supervise clinical care. However, Ms D's scope of practice was confined to mental health, and she was therefore unable to provide clinical care to the residents at MLW. Ms D was therefore supported in her role by senior RN E, who was responsible for the oversight of clinical care.

179. However, RN E was employed for only two days per week. Her duties included monitoring, documentation and care delivery, investigating and implementing quality issues arising from accident/incident reports, organising family meetings, staff orientation and audits, and assisting the Nurse Manager with staff appraisals.

180. In response to my provisional opinion, MLW submitted that its audit one month prior to Mr A's admission concluded that it had sufficient staff levels and mix to reasonably ensure that its staff could meet the health and personal needs of all residents at all times. It submitted that its system for recording staff members' actual hours worked shows that neither Ms D nor RN E worked excessive hours between 22 Month 2 and 29 Month 8.

181. Mrs Grant stated, "Clinical management … deals very much with clinical practice, responsibilities, line management and supervision of caregivers." Ms D was unable to provide clinical supervision for the RNs as this was outside her scope of practice. Furthermore (as noted above) there is no evidence that MLW responded to concerns expressed multiple times by Ms D about workloads. RN E's workload exceeded her allocated hours and there was therefore insufficient time for her to fulfil her responsibility to oversee clinical care issues adequately, or to follow up on clinical decisions and supervise RNs and care assistants. MLW's submission that staffing levels and mix were in line with relevant standards prior to Mr A's arrival at MLW does not amount to evidence of the workload during Mr A's stay. I also consider that the evidence of the number of hours worked by Ms D and RN E is not determinative of the workload they experienced during the hours that they did work. No one person held responsibility for clinical governance, supervision and communication, and staff appeared to be confused over their roles and responsibilities. I therefore remain of the view, with reference to Mrs Grant's advice, that the clinical management systems at MLW during Mr A's stay lacked continuity and were fragmented.

Orientation

182. In 2010/2011 MLW had a four-week orientation programme for its Nurse Manager, which specified clear outcomes for the programme. There was also a self-directed learning package and a feedback form for new staff members to complete at the end of three months.

183. Ms D and RN E stated that the orientation they received was insufficient to orientate them to all areas of the facility and all shifts. They were both given a self-directed orientation package that comprised a generic tick list that was not tailored to their particular roles. RN E was given the orientation package eight months after she started. Ms D stated that she was given some orientation by the Village Manager, mostly relating to financial concerns. She said she felt unsupported, and much of the documentation she needed for her role she completed in her own time. I accept Mrs Grant's advice that the orientation system in place at MLW in 2010/2011 was "ad hoc", brief, and lacked structure.

Compliance with policies and procedures

184. In response to my provisional opinion, MLW submitted that it had adequate systems for communication with residents' families, to monitor residents' weights, and to manage residents' wounds. MLW submitted that recent audits demonstrated that its policies and procedures met the requirements of the New Zealand Health and Disability Sector Standards. I accept this submission. I acknowledge that MLW provided its staff with guidelines, policies and procedures in the care of the elderly.

MLW's "Clinical Guidelines for Residential Care Facilities" covers topics such as nursing documentation and care planning, skin integrity, and resident handling. There were also specific policies regarding pain management, falls management, nutrition and diet, and wound management, all of which were relevant to Mr A's care needs. There were also guidelines on the recording of patient care planning, delivery and evaluation.

185. However, it is also MLW's responsibility to ensure its staff comply with such policies. In response to my provisional opinion, MLW submitted that it took steps to ensure there was sufficient oversight of the clinical care at MLW. It noted that it undertook monthly analysis of data, reviews of documents at monthly nurse managers' meetings, education sessions for new/changed policies, internal audits of data including care plans and medication management, and monthly on-site visits by senior management.

186. Despite the steps that MLW says occurred, as has been noted above, a number of staff failed to adhere to the relevant policies, and Mr A received inadequate care. The deficiencies in the care provided to Mr A were not the results of isolated incidents involving one or two staff. There were numerous RNs and care staff involved in Mr A's care in the five months he was a resident at MLW. The shortcomings were common to many of those staff. An employer such as MLW is ultimately responsible for such widespread failures of its staff as, without staff compliance, policies become meaningless. As stated in a previous Opinion:[23]

> "The inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that did not sufficiently support and assist staff to do what was required of them. [The rest home] as an organisation must bear overall responsibility for this."

187. I also note Mrs Grant's criticisms of the Case Management policy. She stated that it is common for aged care facilities to allocate patients to a case manager who is responsible for completing documentation specific to that patient's needs, which includes weight, reassessment of risk areas such as falls and pressure sores, and pain assessment. Mrs Grant said that the concept is good, but is dependent on full-time staff providing consistency of care. Lapses can occur if the patient has an event when the case manager is not on duty, for example the appropriate change may not be made to the care plan or the risk assessment is not updated.

188. MLW had a duty of care to Mr A to ensure a safe environment for him. This duty was not properly discharged. Multiple staff failed to comply with MLW's policies and procedures, and MLW did not ensure there was adequate clinical oversight or orientation for its staff. MLW did not provide services to Mr A with reasonable care and skill and thereby breached Right 4(1) of the Code.

[23] Opinion 09HDC01783 (28 March 2011), p 24.

Adverse comment — RN I

Hypoglycaemic incident

189. Mr A's BSLs were unstable. From Month 4, MLW staff were in regular contact with a specialist diabetic nurse for advice about the management of Mr A's diabetes, in particular the adjustment of his insulin dosage in relation to his BSL scores.

190. When Mr A returned to MLW from the public hospital on the afternoon of 8 Month 6, after a seven-day admission for treatment of a penile infection, his daughter found him to be sleepy and unresponsive. RN I assessed Mr A's BSL, which was very low at 1.8mmol/L, and considered that he was hypoglycaemic. While waiting for an ambulance to transfer Mr A to the public hospital, RN I attempted to give Mr A sugared water and jellybeans to raise his blood sugar. However, Mr A's diminished level of consciousness affected his ability to swallow and he choked on the jellybeans.

191. Mrs Grant advised that RN I should have assessed Mr A's status when he returned from the hospital, found out when he last had food and fluids, and assessed his BSL. It was inappropriate for her to try to feed Mr A when he was unresponsive, as he was at risk of choking and pulmonary aspiration. In response to my provisional opinion, RN I said that she had tried to find a glucagon pen but was unable to, and decided to give him the sweet drink and jellybeans as she was concerned about his condition.

192. While I acknowledge RN I's statements, Mrs Grant said that once RN I found that Mr A was not able to be roused and his BSL was very low, she should have sought medical attention immediately. Mrs Grant advised that the management of Mr A's hypoglycaemic attack was a mild departure from acceptable standards of practice. I agree. While I have decided that her actions do not amount to a breach of the Code in this instance, RN I should reflect on her care in this case.

Additional comment

193. Metlifecare Ltd conducted an investigation into the care provided to Mr A and found that there were deficiencies in communication, care planning, and the documentation of his wound care.

194. A programme of education and training was provided to all MLW staff in 2010/2011, focusing specifically on the areas identified by the investigation, in particular, communication, prevention and management of pressure areas and the care of wounds, liaison with relevant clinical experts, and palliative and end-of-life care.

195. As a result of the investigation, changes have been made to the management of pressure area care, assessment of wounds, individual care plans, and accessing expert advice. Patient Waterlow assessments are reviewed three monthly and discussed at weekly clinical meetings by the assigned nurse, doctor, and a clinical nurse specialist as necessary.

196. Mrs Grant stated that she has considered the actions that MLW has taken to change its systems and processes as a result of Mr A's case, and is of the opinion that these changes will "go some way to ensuring that clinical care is provided to meet the needs of complex patients".

Recommendations

197. The following recommendations made in my provisional opinion have been complied with: Ms D and RN E have apologised to Mr A's family.

198. I recommend that Metlifecare Wairarapa Ltd provide to HDC by **28 February 2014**:

- a written apology to Mr A's family for breaching the Code and failing to provide Mr A with adequate treatment and care. The apology is to be sent to HDC for forwarding to Mr A's family;

199. I also recommend that Metlifecare Wairarapa Ltd provide to HDC by **15 May 2014**:

- a review of training provided to staff in relation to communication, diabetes management, prevention and management of pressure areas and falls, pressure ulcer care, and end-of-life care;
- evidence that all relevant staff have been trained in the documentation of pressure wound care, and that the Wound Assessment and Treatment Tool forms are recorded accurately and updated as necessary; and
- evidence of ongoing refresher updates of the training provided to staff.

Follow-up actions

200.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Metlifecare Wairarapa Ltd, will be sent to the the district health board 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 Metlifecare Wairarapa Ltd, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of Ms D, RN E, and RN I.

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

Appendix A — Independent advice to the Commissioner

The following preliminary expert advice was obtained from Mrs Jan Grant, a registered nurse with expertise in aged care:

"**Purpose**: *To provide independent expert advice in relation to the care provided [to] [Mr A] by Metlifecare Wairarapa*.

I have been asked to provide an opinion to the Commissioner on Case 11/00686. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. Enclosed is a copy of my qualifications which outline my training and experience relevant to the area of expertise to be called upon in compiling this report. I have read all of the supporting information.

Background

[Mr A], an 89 year old male, was admitted to Metlifecare Wairarapa (MLW) on the 1st [Month 3] having been discharged from the public hospital. His discharge summary lists his diagnoses as:

- # R) NOF
- Delirium
- Urinary infection.

His on going medical problems are listed as:

- 2010 # R) NOF, post op delirium, urinary infection HDS 91/200
- Dementia
- Diabetes type 2 on insulin
- Hypertension
- L) MAC stroke 2001, good recovery
- L) carotid endarterectomy 2002
- R) cataract.

[Mr A] was on a number of medications. His mobility on discharge was listed as to be walking with 2 person assistance. He was noted to have poor memory and was assessed as requiring hospital level care. [Mr A] had several medical issues during his time at MLW which required him to be admitted to the public hospital. He became unwell and died on 12 [Month 8].

General standard of nursing documentation

When reviewing the standard of nursing documentation one reviews the Clinical File and supporting documentation. On admission [Mr A] had a Lifestyle Plan completed. This was an 11 page document which commenced with name, NOK information, NHI number. It notes that the person undertaking the assessment was [RN E] and is signed by her with her designation of R N.

The next part of the Plan was Base Line recordings and these are listed as:

- Weight 68.8 kg
- Blood pressure 110/52
- Pulse 100.

Medical issues:

- L) # NOF [13 Month 1]
- Post op delirium/dementia,
- L) CVA 2001 — Diabetic (on insulin)
- R) cataract with poor vision,
- Poor hearing,
- Benign prostatic hypertrophy,
- Carotid stenosis.

The next part of the Lifestyle Plan lists Care Needs. This was completed on the 6 [Month 3] commencing with:

- Hygiene needs — 2 person transfer shower chair — full body wash on non shower days.
- Rest and sleep — [Mr A] can be restless at times, ensure he is checked regularly when in bed and toileted as required, [Mr A] has a high low bed, ensure this is at the lowest point at all times. Ensure mattress is on floor when in bed.
- Nutrition — Full diet, see attached Dietary profile, kitchen given full diet profile. Prone to dehydration. Staff to push fluids and monitor fluid intake. Ensure [Mr A] has fluids in front of him when sitting up.
- Mobility — [Mr A] requires full staff assistance for all mobility. [Mr A] has frozen shoulders and finds it difficult to lift his arms up. Falls assessment — 10 high risk of falls. He will try to get up to the toilet himself and is at very high risk for falls. Mattress on the floor beside his bed.
- Elimination — Staff to toilet regularly. To be assisted onto the commode chair in AM for daily BA. Staff to document bowel action daily. Tenna supper pad during the day. Family have requested underwear or net over pads, not both. Tab pad at night.
- Communication — [Mr A] can hear when spoken to closely and can communicate to staff and understand instructions.
- Memory. Short term — forgetful. Long term — appears to be good. Able to join in conversations with other men. Memory impaired — age related. Orientation to time and place — Yes. Recognises staff and family — Yes. Mood — settled. Perception — good. Behaviour — No concerns re behaviour. Wandering — No.

- Pain Management. — [Mr A] is able to let staff know if he has pain. Regular Paracetamol charted.
- Vision — Poor vision. Not able to read or see well enough to write.
- Hearing — Poor hearing. Not able to hear in a crowded room. Speak clearly and directly to [Mr A] to enable him to hear you.
- Culture/Spirituality — nothing noted.
- Sexuality. Staff to involve [Mr A] in activities that suit him. Enjoys music. Enjoys sitting at the men's table for lunch having a chat. Staff to ensure [Mr A] is always well presented, clothes are neat.
- Psycho-social needs — Poor hearing, however likes to be with company. Past occupation […]. [Mr A's] family will look after money management.
- Death and Dying — [Mr A] wishes to be buried. [Company name] undertakers.
- Family/significant other input — supportive family.
- Risk Factors — Falls very high risk. Family have declined hip protector and lap belt. They say it is [Mr A's] wish to maintain his independence and dignity and they accept as a family that he may fall. Restraint — No. Skin integrity — Very high risk. Weight Loss — weigh monthly. Challenging behaviour — No.

The final page of the Lifestyle Plan lists the Key Worker as [Ms G]. The Case Manager as [name]. It is signed by the residents advocate [Mrs B].

The Life Style Care Plan was updated on 22 [Month 5], with changes added to take account of [Mr A's] increasing frailty.

A Falls Risk Assessment Chart shows that assessments were undertaken on 1 [Month 3], 6 [Month 3], 22 [Month 5]. The first assessment identifies [Mr A] as a Medium Falls Risk and the 2nd and 3rd assessments identify him as a High Falls Risk.

A Waterlow Pressure Area risk assessment tool was completed on three separate occasions; these are dated:

- 1 [Month 3]
- 6 [Month 3]
- 22 [Month 5].

All of these assessments rated [Mr A] as being of a high risk of developing a pressure area with the final one, dated 22 [Month 5], as being a very high risk.

A Continence Management assessment was undertaken on 1 [Month 3]. This shows that [Mr A] had faecal and urinary incontinence. He had an IDC [indwelling catheter]. He required 2 people to assist with mobility and he was on a

toileting programme. He had a pad for night time and his skin was described as fragile. This assessment was signed by a Registered Nurse.

An Activity Assessment was undertaken by the Diversional Therapist and dated 16 [Month 3]. This form lists [Mr A's] life history and includes activities that he may be interested in. It also lists his individual life goals and functional goals. It is summarised with an Activity Plan. It was reviewed on 17 [Month 6].

Also provided was the Activity Attendance sheets which show what activity [Mr A] took part in. In reviewing these sheets it is noted that [Mr A] had good participation in activities in only 5 days in [Month 4], limited participation in [Month 5], 3 days' limited participation in [Month 6], 2 days' participation in [Month 7], and no participation in activities in [Month 8]. It does state that he had limited conversation and was visited by family and friends.

The Progress Notes form the major part of reviewing the care and services given to [Mr A]. These notes are in dated order and are written up by Care Staff and Registered Nurses.

The first entry is dated the day of admission and lists [Mr A's] needs and a history pre-admission. There is a stamp which lists 'FAMILY CONTACT' and this is seen throughout the Progress Notes.

The Progress Notes are generally written each shift but there are a number of days and shifts when no documentation was written. Some of the PM shifts show no documentation for the shifts. I did not view the policy for documentation from MLW which would have outlined the facility requirements.

It would be general practice for staff to document each shift if a patient is unwell, has multiple medical-nursing problems and needed to have care outcomes assessed and evaluated. I am of the opinion that [Mr A] would have come under this category. He required constant monitoring of nutritional needs including diabetic BSL, safety/mobility needs and wound care needs.

Many of the entries are documented by Care Staff and this is completely acceptable if the patient is stable. However in the case of [Mr A] I would have expected to have the notes counter-signed by a Registered Nurse. There is more Registered Nursing input into the Clinical Progress Notes in [Month 7] and [Month 8] when [Mr A] was requiring more intensive nursing care but again there are shifts that have been missed.

Nursing requirements in relation to documentation are outlined in the Competencies for Registered Nurse Scope of Practice New Zealand Council of New Zealand 2009.

- Competency 2.3 Ensures documentation is accurate and maintains confidentially of information — Maintains clear, concise, timely, accurate and current client records within a legal and ethical framework.

The Health and Disability Standards state that a plan should be individualised, accurate and up to date.

In summary I think there are parts of the Progress Notes that do demonstrate what care was delivered and they also show evaluations of care and treatment but these are not consistent throughout the notes. Especially where there are shifts that have been missed and nothing recorded.

The Care Plan was brief in its clinical interventions and did not fully document what Care Staff and Registered Nurses should have been doing in relation to a lot of [Mr A's] care.

The general standard of nursing documentation in my opinion is a moderate departure from expected standard of practice.

Monitoring of [Mr A's] weight and fluid intake

[Mr A's] weight was listed on admission as 68.8kg. It does not state what height [Mr A] was, so it is difficult to assess if he was within normal limits for his body mass index. The next weight was taken on 29 [Month 6] and is listed as 55.7kg — a loss of 13.1kg in 120 days. Most current literature on weight loss in the elderly indicates that any weight loss greater than 5% over a 6 month period should be investigated. (Lewko)

Good clinical practice would have seen that [Mr A's] weight should have been taken monthly following admission. An assessment should have been undertaken specifically for diet and weight loss in the event of a loss of more than 2–3 kg per month. This would have been more important as [Mr A] was a diabetic and supplied with a diabetic diet. The Care Plan does not state the frequency of when [Mr A] should have been weighed. Nor does it state to monitor his oral food input. Once his weight loss had been identified, no proactive measures where undertaken to identify and then seek specialist dietetic advice. There is no evidence in the medical notes that the Medical Officer providing care to [Mr A] was informed of the weight loss. All Age Care Facilities should have a dietician or have the availability to access a dietician through their local DHB.

It is also identified through the Clinical Progress Notes that [Mr A's] blood sugar levels where very unstable and a Food Recall chart would have assisted in allowing an accurate assessment of both the amount and type of oral food intake.

It is noted that staff did document in the Progress Notes their opinion as to whether [Mr A] did eat his meals but statements such as 'had good breakfast' —

'good meals and fluid intake' are very subjective and give no real account of the amounts of food and fluid taken.

Fluid Balance Charts were commenced in [Month 5] but did not include oral food intake; many of the Fluid Balance Charts are not consistently filled in. There are obvious gaps where staff have failed to fill in both input and output. Output is also not consistently filled in hence it is difficult to get an accurate picture.

The Aged Care Contract requires that accurate documentation of care and appropriate weight monitoring is carried out.

- The management of [Mr A's] weight loss in my opinion was a moderate departure from expected standards of practice.
- The management of Fluid Balance Charts is in my opinion a mild departure from expected standards of practice.

The Management of the 8th [Month 6] incident

The clinical notes on the 8th [Month 6] state:

'
- returned from [public hospital] 1500hrs
- Paraphimosis not treated.
- Treated for urosepsis with antibiotics.
- Nursing referral mentions pressure areas on heel, shin, sacrum. Dressings insitu.
- 1700hrs — unable to wake for tea — BSL 1.8 given 5 tsp dissolved sugar + 2 jelly beans — swallowing difficult. BSL 2 [Month 7] 111 ambulance called. Family present transferred to [public hospital] after IV glucose given by paramedics.
- Stable at 7.9 at 2000hrs in [public hospital] withhold … (meds)
- 21.30hrs returned from [public hospital] take BSL x 3 overnight
- Had CT scan has a chronic subdural (R) 1cm. Not for treatment.

Nocte. '[Mr A] has been checked ½ hrly this duty by the RN. He has been responsive and alert. He stated he was feeling cold, temp 35.5. Extra blankets put on [Mr A], heater turned on with good effect (very cold night). [Mr A] looks pale, anaemia related to renal insufficiency. BS 7.3 at 0300hrs BS 7.7 at 0600hrs. Had sips of water throughout the night. In the discharge summary it states that [Mr A] needs to be turned regularly due to pressure areas, [Mr A] has moved himself around quite often. Catheter drained 550mls clear urine this duty.'
Signed by RN

The documentation written by [Mr A's] family states that they visited their father at 5.20pm to find a caregiver trying to feed [Mr A] dinner. The caregiver asked the family to wake [Mr A] as he appeared asleep. The family were not able to do this and requested a RN. The Registered Nurse on reviewing [Mr A] took a BSL reading — this was 1.8. The RN attempted to give sugar in water and 3 jellybeans

which [Mr A] choked on. An ambulance was contacted and [Mr A] was attended to and taken to public hospital.

In reviewing the incident, it is clear that [Mr A] was suffering from hypoglycaemia and was not able to be roused. It was inappropriate for the Care Staff to commence feeding as he was not able to swallow or respond. There was a real risk of aspiration and choking. The correct action was for the Registered Nurse to take the blood sugar but once identifying that it was 1.8 and that [Mr A] was not able to be roused then medical assistance should have been sought immediately. Attempting to give fluids and jelly beans put the patient at a high risk of aspiration.

It is noted that the following comment was passed — that [Mr A] was sleepy since arriving back at the facility. This would have indicated that his blood sugar was low for some time. When receiving a patient back into care it would have been appropriate to assess the BSL and what if any food/insulin had been received prior to arriving back.

Following the event an Incident Form should have been completed and the event fully reviewed.

It is noted in the Progress Notes that staff did contact specialist diabetic nurses in relation to [Mr A's] insulin and BSL.

- The management of the hypoglycaemic attack was in my opinion a mild departure from acceptable standards of practice.

Communication between nursing staff and Dr F

Medical notes indicate that [Mr A] was visited 12 times by a doctor, on:

- 3 [Month 3]
- 19 [Month 4]
- 25 [Month 4]
- 9 [Month 5]
- 1 [Month 6]
- 10 [Month 6]
- 1 [Month 7]
- 4 [Month 7]
- 6 [Month 7]
- 9 [Month 8]
- 11 [Month 8]

The reasons for visiting and action of care is well documented. There is nothing in the Medical Clinical Notes to show that nursing staff had discussed several issues of [Mr A's] care in relation to weight loss and frequency of falls. There is nothing

in the Medical Clinical Notes in relation to the wounds/pressure areas until 9 [Month 8] when the wounds were severe.

The Nursing Progress Notes demonstrate that [Mr A] was complex and at times a challenging patient for care staff. He had a number of falls, his blood sugar was unstable, and he developed several wounds that were difficult to treat and manage. Registered Staff should have in my opinion sought medical advice not only on the unstable diabetics which they did but also on the falls, weight loss and wound care. Support of the medical staff would have assisted in the care and treatment planning for [Mr A]. It also would have allowed the medical team to discuss these issues with the family.

- It is my opinion that communication and advice should have been sought from the medical team in a more timely manner. This would be viewed as a mild departure form acceptable standards.

Care Plan, particularly pressure area prevention/wound documentation

The Initial Care and Assessment documentation demonstrates that staff did assess and note that [Mr A] was a high risk for developing pressure areas. This was reviewed on 3 occasions and indicates that his risk increased from a 17 on admission to a 25 on 22 [Month 5]. The area in the Care Plan which addresses this issue would be the Skin Integrity section. On the Initial Care Plan it is identified that he had fragile skin and had had a number of falls which resulted in skin tears. The Care Plan was updated on 22 [Month 5] and notes that he had a pressure area on his right heel and that his sacrum was fragile. Staff are asked in the Care Plan to observe skin on shower days and report concerns. It notes that [Mr A] sleeps on a pressure reducing mattress and that he has a Spenko cushion on his chair. It also states that he has dry skin and to apply moisturisers after cares.

The Progress Notes have some but not adequate evaluation of [Mr A's] skin and pressure areas. An entry on 23 [Month 4] '*… very red groin area zinc and castor oil applied to this. …'*

There are several entries in the Progress Notes in relation to staff attending to [Mr A's] penile area.

On 20 [Month 5], the Care Giver has documented, '*A pressure area was noted on the right heel. Reported to the RN who viewed it*.' There is no evidence in the Wound Care charts that I viewed that this pressure area was documented (the first date in relation to the right heel wound is listed as 20 [Month 6]), nor was there evidence in the Care Plan that this wound was listed. The Registered Nurse did write in the Clinical Progress Notes on 21 [Month 5], '*area on sacrum looking fragile ? need for an air mattress*. …'

On 24 [Month 5] the notes state, '*Dressing put on his L foot to the side — has black area there RN informed of this dressed. …'* 28 [Month 5]. '*[Mr A] was on the bed as RN re dressed his leg and R heel. …'*

Following [Mr A's] admission and return to MLW on 8 [Month 6], the nursing discharge letter notes that [Mr A] had pressure areas on his sacrum, shin and heel. He had been nursed on an air mattress in [the public hospital] and the wounds had been dressed. A wound assessment and treatment tool was commenced at this time in relation to the right heel; it shows the size of the wound and what treatment was undertaken. The front of this assessment tool states that the wound was the right heel. No other information was completed on the front of this sheet. Other wound assessment tools are partially completed for [Mr A's] other wounds. Several of the earlier wounds were documented on Progress Notes but not entered onto Wound Assessment charts.

Specialist nursing advice was sought and the Nurse visited on 27th [Month 7]. An air mattress was placed on [Mr A's] bed on 11 [Month 8].

The Progress Notes indicate that [Mr A] was a challenge in relation to his mobility and there are many entries in the notes to show that he mobilised independently, removed dressings and sustained new wounds when he fell. It is also obvious that he had multiple medical problems along with his general on going frailty.

In summary Wound Care management and Pressure Area care did not appear consistent and was not well documented. The Care Plan was not updated to show the level of wounds and the nursing interventions required in relation to Pressure Area care. A more proactive approach would have ensured that an air mattress should have been used earlier. Medical staff and nursing specialist input would also have ensured a more consistence approach to care.

Communication with the family was poor and family indicated that they were not aware of the severity of [Mr A's] wounds until after his death.

- The prevention, care and documentation of [Mr A's] wounds, pressure area and treatments are in my opinion a moderate departure from expected standard of practice.

Summary

[Mr A] presented as a complex patient with multiple medical and nursing problems. In reviewing the general standard of care one cannot just take into account each individual issue that [Mr A] presented with but rather all of the issues and the care provided. Each of the medical/nursing issues that [Mr A] had were complex and required, in my opinion, more input from specialist staff. A team approach involving all members of the multidisciplinary team such as medical staff/specialist nurses would have ensured that staff were not out of their depth and that there was advice for the general staff when needed.

Jan Grant"

Further expert advice

Ms Grant provided the following further advice:

"I have been asked to provide further advice:

Consumer: [Mr A]
Provider: Metlifecare Wairarapa (MLC)
File Number: 11/00686
Date: 28 October 2012
I have provided advice on the 28th November 2011 and 18 July 2012.
For this advice I have read all of the support documentation provided.

Comment on the standard and appropriateness of nursing care provided by Metlifecare Wairarapa

As documented in my advice dated 28th November 2011 and having read the extra documentation provided I am of the opinion that the care and services provided to [Mr A] did not meet the standard expected in Aged Care. Having read the extra documentation I am of the opinion that there were a number of factors that contributed to the lack of care. I am of the opinion that there was a systematic failure in both management and clinical services. Issues such as lack of clinical supervision, lack of adequate staff, policies not followed, inadequate orientation and poor family communication led to a breakdown of good clinical care.

I am of the opinion that my peers would view this as a moderate departure from acceptable standards.

Standards that apply to this case

- MLW will have a contract with the local DHB and there will be clinical requirements contained within this contract.
- MLW will also be audited from a designated audit agency for the requirement in relation to standards New Zealand. This will also include Infection Control Standard, Restraint, Health and Disability sector standards.
- The Nursing Council of New Zealand governs the practice of nurses and defines the scope of practice that nurses can work in. It also lists the competences for registered nurses.
- Standards such as the Code of Health and Disability Services Consumers' Rights also apply.

Senior Registered Nurse [RN E]

The senior registered nurse job description is dated 19/08/2009. It outlines the Key Result areas, Key Tasks/Accountabilities and Performance Objectives/Measures. The Key Result Areas are divided into key tasks — the first being Clinical Leadership followed by Operational, Quality, Professional Standards and Development, Health and Safety and General. The Performance Objectives and each Key Result are listed. The Performance Objectives are specific and clearly documented. It is my opinion that the job description covers all key aspects of a

senior registered nurse and would be fairly typical of what is found in an aged care facility.

[RN E] commenced work as a casual RN in January 2007. She commenced her role as a senior RN in August 2009. The role was for 16 hours per week on Mondays and Tuesdays.

In a statement dated 15.3.2012, [RN E] outlines her roles as

- Following up Incident Forms
- New admissions — ensuring all Care Plans were completed, photos etc
- Three monthly reviews
- Family meeting
- Quality audits
- Arrange three monthly medical visits
- Stock control
- Arrange meetings for care workers and RNs
- Ensure orientation of all new staff — three monthly appraisals of new staff
- Assist with staff appraisals
- Organise all in-service training, take some education sessions
- Act as restraint coordinator
- Monthly checks of medication
- Assist with reassessment
- Act as ACE trainer
- ACC registered nurse for the village
- From time to time take residents wellness clinic.

A record of Professional Development was supplied and I am of the opinion that adequate hours and an appropriate range of topics were listed which would be appropriate for a registered nurse's work load two days per week.

A Registered Nurse Orientation programme was included in the documentation; this was dated as being completed on 12.10.07. No orientation was available for the role of senior registered nurse.

[RN E] responded to questions from HDC dated 15.3.12. In summary she stated that she was unable to complete her tasks due to the staff difficulties at that time and the lack of registered nurses.

She stated her first job on a Monday would be to sort out the roster for the week, as staff would be off sick or having swapped shifts. She stated that there was no staff available for the serviced apartments at that time.

She also stated that it was difficult with medical staff as many of the doctors would visit at different hours and their visit would not be within normal working hours. [RN E] stated that she never went on medical rounds and that it was difficult to get registered nurses to document in the multidisciplinary notes. At the time, staff documented in the clinical notes once a day and this was not always counter-signed by the RN. [RN E] states that there were difficulties with weighs and that the key worker who was listed to a room was responsible for the patient's weighs. There appeared to be confusion over what would happen if the key worker was absent at the date the patient was due to be weighed. She goes on to discuss the wound care process. The RN on the floor was responsible for the wound dressing, subsequent assessment and referrals should it be required. She states there was poor use of a wound assessment tool and poor documentation around wounds.

I am of the opinion, that it was [RN E's] responsibility, as senior nurse at MLW, to ensure that [Mr A] received adequate care and support. This must be taken in the context that [RN E] only worked [2 days per week] and other days it was the responsibility of the registered nurses on the floor to ensure that adequate assessment and care decisions/referrals etc were actioned and followed through. From the documentation and interviews there appears to be lack of a specific person named who is responsible for clinical issues and areas.

Taking all factors into account I am of the opinion that my peers would view this as a mild departure from acceptable standards.

Were the policies and procedures adequate?

MLW presented a number of policies that were in use at the time [Mr A] was a patient. They include:

- Skin care skin integrity learning package — 19 pages issued 2006 updated 2008
- Wound management — issued 2006 updated 2010
- Case management — issued 2001 updated 2010
- Pain management — issued 2000 updated 2008 review date 2010
- Personal hygiene and grooming — issued 2000 updated in 2008 review date 2010
- Dietary requirement form
- Continence management — issued in 2000 updated in 2008
- Falls management — issued 2000 updated 2010
- Guidelines to documentation
- Lifestyle plan form and policy — issued 2000 updated 2010
- Open disclosure — issued 2010.

There were only 11 policies viewed, many had been documented in 2000 and reviewed six to eight years later. The policies with the exception of the Skin

Integrity learning package were brief and lacked detail. The policies did outline the care and service required in relation to the topic, albeit brief e.g. The Lifestyle Plan stated that, *'the plans are evaluated when needs change and no less than once every six months. Evaluations include consultation with the residents, the multi-disciplinary team, resident family and or advocate.'* As noted in my earlier evidence this process was not followed in relation to wound care, weight loss, family communication and documentation.

It is my opinion that the policies and procedures available at the time of [Mr A's] stay were brief and lacked detail. It is my view that this would be viewed as mild by my peers.

Was the orientation of staff training adequate?

Two staff have commented on their orientation. [RN E] stated that 3 days' orientation was not enough time to orientate staff to all areas and all shifts. She also stated at the time of her orientation that she had a tick list to complete and that there wasn't really an orientation.

[Ms D] stated that her orientation '*wasn't good'*; she indicated that she had to find her way around and that she made a list of things that needed to be implemented.

MLW have presented the reviewed orientation (February 2012) which is thorough and has adequate structure. There is on site work orientation for three days and a self-directed learning package. This information lists Resources for Learning, clear objectives and on-going education. There is a Skill checklist for Level One Caregivers. A three month appraisal form is available.

MLW have also presented a Nurse Managers' orientation programme. This appears to be a four week orientation with clear outcomes for the weeks. A self-directed learning package is also included as is a feedback form at the end of three months.

The registered nurse orientation package is now a four day on site buddy system with clear guidelines. It also includes a self-directed learning package, and a three month review.

It is my opinion that the orientation system in place at the time of [Mr A's] admission and stay was brief and lacked structure. It appears that this was ad hoc. Evidence from the documentation showed that the facility was under pressure with staff shortages and lack of on-going clinical oversight.

The review of the orientation process and the documentation that is now presented in my opinion will ensure a more structured robust orientation programme.

Please comment on the appropriateness of the clinical management structure at Metlifecare Wairarapa

Clinical Management in my experience deals very much with clinical practice, responsibilities, line management and supervision of caregivers. The clinical management structure at MLW did not allow for consistency.

The Nurse Manager was unable to provide supervision on the floor as this was outside her scope of practice as defined by Nursing Council. Her role involved more management issues than clinical.

The senior nurse's role was only available for two days per week and it appeared that the workload for her responsibilities exceeded the allocated hours. There also appeared to be confusion over responsibilities of clinical issues.

I am of the opinion that the clinical management systems at MLW during [Mr A's] stay lacked continuity and was fragmented. No one person held responsibility for clinical governance, supervision and communication. Staff appeared confused over their roles and responsibilities and there was insufficient time for the senior registered nurse to complete her tasks.

Was Nurse Manager [Ms D] appropriately qualified and experienced for the position of clinical nurse manger?

[Ms D's] CV outlines her work experience both in New Zealand and [overseas]. She qualified as [an enrolled mental health nurse in 1979 and a registered mental health nurse in 1986[. She worked in a number of positions both here and [overseas]. Her on-going education included courses in

- Nursing process
- Social care
- Sign language
- Teaching and assessing in clinical practice
- Clinical supervision
- Management training
- Mental health recovery
- Gerontological assessment 2007
- Health assessment 2009.

Her education and training is also listed and includes a broad range of topics relevant to her clinical/management practice.

Before Month 12 her practicing certificate limited her to clinical practice in mental health settings. Following her education and approval from nursing council she was able to practice in aged care settings.

Evidence was available that MLW was fully aware of this on employment in 2007. As [Ms D] has stated, '*I wasn't allowed any direct clinical contact with the resident.'*

Three performance appraisals for [Ms D] were included in the evidence. These relate to the Scope of Practice for registered nurses. Certainly within the area Management of Nursing Care it can be viewed that this was applicable for a registered nurse as they included competencies for registered nurses and relate to areas of nursing assessment.

The document also states that: '*Prior to undertaking this assessment you are advised to read Nursing Council's document Competencies for the Registered Nurse scope of practice. …*' There is nothing in the evaluation to acknowledge that [Ms D] had worked only within the scope of practice of Mental Health. The supporting documents indicate that the organisation expected clinical practice as part of [Ms D's] employment.

In [Ms D's] interview with HDC on 17 May 2012 she states that she was employed to run the facility. She states that there would always be a RN on duty as she could not have any direct contact with residents. Her role was mainly around management and that [RN E] was the senior RN and managed the clinical side of the business (working 2 days a week) with [senior management staff who were not on site]. [Ms D] stated that she asked for [RN E's] hours to be increased to help cope with the work load but this request was denied by senior management.

[Ms D] also documented that she was going in when staff were off sick and working as a care giver. She also stated when she commenced employment she was told that she should be the RN on the floor if an RN was off sick, she explained that she was unable to do this due to her scope of practice. She states that she never felt supported by senior nursing management.

[Ms D] took a total of 4 weeks' stress/unplanned leave in 2011.

Performance Appraisals identify a theme of excessive work load and stress; in [Month 8] [Ms D] has documented: '*Have been working to reduce working hours and think about work load prioritising able to de-escalate stress in others easily, but as always I remain hard on myself always wanting the best outcomes to promote MLC.' 'Difficult at times with workload to not be the ambulance at the bottom of the cliff.' 'Acknowledging that I am unable to get through the amount of work in one day.'*

In 2010 comments such as: '*Feel overwhelmed with the amount of workload' 'Difficult at times to balance wrk/life as on call 24/7 majority — staff sickness is issue.'* 2009; '*I continue to feel overloaded with work and at times am unable to complete projects to a high standard. I believe the structure is not conclusive to the retention and long term employment of N.M's I continue to receive clinical*

supervision but even this has been difficult due to hrs of work' 'I continue to expect high standards from all including myself sometimes this can lead to my feeling overwhelmed with such a large responsibility and workload unsure how NM at Wairarapa can continue to work at this level long term.'

Summary

It is my opinion that [Ms D] was appropriately qualified for the position as Facility Manager but not qualified for the position as Clinical Nurse Manager. She was unable to provide clinical supervision for the Registered Nurses as this was outside her scope of practice as identified by Nursing Council. Evidence from documentation presented shows that there was definitely a blurring of boundaries, and expectations from the senior nursing management of MLW. It is my opinion that evidence shows that the workload was excessive and that [Ms D] identified this as early as 2009. She stated that she was expected to be on call 24/7 and that most calls she received related to staff sickness etc. She requested an increase in senior registered nursing hours to support her in the role and this was denied.

It is my view that [Ms D] cannot be held responsible for any clinical decisions that were inappropriate as it was not within her scope of practice as defined by nursing council which consigned her scope of practice to mental health until Month 12 hence she was unable to supervise and direct care in an Aged Care setting. Evidence is available to show that senior staff knew and understood the limitations to her practice.

Was there sufficient oversight of the RNs and care staff?

Reading all of the evidence provided I am of the opinion that there was not adequate oversight for the registered nurses at MLW. Although there was a senior nurse she was only employed two days per week and did not have sufficient time to oversee clinical care issues, follow up on clinical decisions and supervise registered nurses and care givers. There appeared to be staff shortages at this time.

The appropriateness of allocating RN case managers for residents.

It is common for aged care facilities to allocate resident/patients to a case manager/registered nurse who are responsible for completing documentation which is specific to their needs. This would include ensuring the care plan is updated and also ensuring that regular reviews are undertaken. These would include weight, reassessment of risk issues such as pressure areas, fall risk assessment and pain assessment. Basically the assessments of all requirements are for monthly/three monthly reviews. The concept is good but is lacking in many facilities where the staff allocated to a specific resident are not in full time employment, and may only work part time say 2 shifts a week or in some cases, less. Issues arise when the case manager is away and the patient has an event which requires changing the care plan or updating the risk assessment. These tend not to be updated with staff thinking that the case manager will complete this. For this system to work, it is my opinion that there needs to be robust policies and procedures and on-going education/supervision and good communication from all

shifts. There also needs to be a higher level of taking responsibility by a senior nurse manager for RNs in relation to documentation and on-going evaluation.

The appropriateness of a separate wound folder held in the manager's office.

Residents' and patients' wound care should be treated as individual treatment and as such a separate assessment form and on-going evaluation kept in their clinical notes. In my experience many facilities have a list which may be displayed in folders or treatment rooms which identify who is having wound care but not the assessment or management of wound care. All documentation used for that should be kept in individual files. My initial advice was that the wound management was not consistent and not well documented. The nursing care plan was not updated. It is noted that MLW has improved processes and all wound care is now documented on individual wound charts which are kept in the patient's individual file. This action will allow for a much improved process and on-going care in relation to wound management.

Summary

I believe from the evidence that I have read including the statements for all concerned that there was a systematic failure in systems both managerial and clinical at the time [Mr A] was a patient. My initial evidence was that [Mr A] was a complex patient with multiple medical problems and care needs. It is my view that there was neither the structure nor the supervision in place to provide this care. These areas of care are documented in my initial advice.

I have read the actions that MLW have initiated to change systems and processes and it is my opinion that these will go some way to ensuring that clinical care is provided to meet the needs of complex patients.

Jan Grant"