A Rest Home

Registered Nurse, Mrs D

Registered Nurse/Licensee of the Rest Home, Mrs E

Manager of the Rest Home, Mr G

General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 01HDC09857)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Complainant / Consumer's daughter
Mrs B	Consumer (deceased)
Dr C	General practitioner
Mrs D	Registered nurse
Mr E	Licensee
Mrs E	Licensee/Registered nurse
Mrs F	Consumer's sister
Mr G	Manager
Dr H	Doctor at the surgery
Mr I	Gerontology nurse practitioner

Complaint

On 7 September 2001 the Commissioner received a complaint from Ms A about services provided to her late mother, Mrs B, by a retirement home, and general practitioner Dr C.

The complaint about the rest home was summarised as follows:

- *Despite Mrs B having several falls, no preventative measures were put in place, and no bed rails were available.*
- *Mrs B's fall on 10 August 2001 was not documented.*
- *Mrs B's incontinence was not properly managed.*
- *The rest home failed to recognise and manage Mrs B's deteriorating medical condition and mobility.*
- *On 17 August 2001 Mrs B complained to her daughter that a staff member assaulted her on or about 16 August 2001.*
- *Despite being alerted to Mrs B's deterioration by her family, the rest home failed to admit Mrs B to hospital. She died a few days later.*
- *There was inadequate liaison between the rest home and Dr C.*

On 8 August 2002 the investigation was extended and registered nurse Mrs D and owner/registered nurse Mrs E were notified of the above issues, and the following additional two points:

- *A nursing assessment was not undertaken during Mrs B's admission to the rest home.*
- *Documentation of Mrs B's care was inadequate.*

The complaint about Dr C was summarised as follows:

- *Dr C failed to recognise Mrs B's deteriorating medical condition and respond appropriately.*
- *Dr C failed to get Mrs B promptly assessed for hospital level care.*

- *There was inadequate liaison between the rest home and Dr C.*

An investigation was commenced on 8 October 2001.

Information reviewed

- Information from Ms A
- Information from Mrs F (Mrs B's sister)
- Information supplied by Mr G
- Information supplied by Mrs E
- Information supplied by Mrs D
- The rest home's policies and procedures relevant to the complaint
- Nursing notes supplied by the rest home
- Medical notes supplied by Dr C
- Medical records from the public hospital
- Ministry of Health's Audit Report of the rest home
- The Old People's Homes Regulations 1987
- National Contract For Age Related Residential Care Services (Ministry of Health)

Independent expert advice was obtained from Dr Tessa Turnbull, a general practitioner with a special interest in care of the elderly, and Ms Shirley Hughes, a registered nurse with expertise in care of the elderly.

Information gathered during investigation

Overview of events
Mrs B, aged 78 years, was admitted to the rest home on 2 August 2001. Following several falls Mrs B's mobility deteriorated from being mobile with a walker when she was admitted, to not being able to sit, walk, or transfer without assistance. She became increasingly confused, unsettled at night, and incontinent of urine.

On 18 August 2001 her daughter, Ms A, was so concerned about her mother's deterioration that she took her to a public hospital. Mrs B was admitted with an exacerbation of her multiple medical problems, skin tears to her lower legs, and a severe perineal rash caused by urine burns. Mrs B's condition continued to deteriorate and she died a few days later.

The rest home
At the time of these events the rest home was licensed for 26 residents and employed eight staff (one registered nurse and seven caregivers). The residents were all frail elderly, requiring assistance with daily living tasks. The rest home did not cater for residents requiring private hospital level care or a secure dementia environment. The rest home was

awarded a Certificate of Registration from Telarc Limited (a basic quality management system) in 1999.

The Licensees
At the time of this complaint Mrs E and her husband, Mr E, were the licensees of the rest home. Mr E was responsible for general accounting and administration duties. Mrs E, in conjunction with her husband and her brother, Mr G, was co-director of their trading company. The company owned another rest home. At the time of these events, Mr G advised me that there was a close working relationship between the two rest homes, and Mrs E and Mr G would divide their time between both rest homes during the week. Mrs E denies that the working relationship was as close as described by Mr G.

Mrs E
Mrs E is a registered nurse, with a current practising certificate, and is described in the rest home's documentation as the matron, "responsible for the overall care of residents" as well as staff management and training. Mrs E stated that she called into the rest home on a daily basis and was available to answer any questions that staff had about residents' care. She denied that her role at the rest home extended beyond having a financial interest in the company, as a co-director and owner. Mr G advised that Mrs E provided on-call registered nurse cover to the rest home and "popped in" most days. He would ask Mrs E to look at a resident if he had concerns and, although she did not record her visits to patients, Mrs E gave directions to staff about residents' care.

Mr G
Mr G is the manager of the rest home, and all staff report to him. He has been involved with the rest home for approximately 12 years, initially as a licensee, and as the manager for non-clinical services for the last six years. His usual hours of work are 7am to 7pm every day, as well as being on call. Mr G was responsible for general staff management, the running of the home, and admissions.

In April 2002 Mr G became the sole manager and licensee of the rest home.

Mrs D
Mrs D is employed as the registered nurse for the rest home and has a current practising certificate. She has approximately 25 years' work experience with elderly patients. She had been employed at the rest home for approximately six years at the time of Mrs B's admission, and had previously worked at a rest home for 21 years. Her usual hours of work were 6.30am to 2.30pm Monday to Friday. I was not provided with a job description for her position.

General practitioner cover
The rest home contracts two general practitioners to provide medical services to residents. However, respite residents are permitted to retain their general practitioner if they wish. At the time of this complaint, the rest home did not have procedures or policies in place in regard to visiting practitioners' responsibilities.

Mrs B
Mrs B was a 78-year-old woman with multiple medical problems. She had had a pacemaker for approximately ten years and congestive heart failure for two years. Mrs B

had been a patient of Dr C for five years and she attended him regularly. During 2001 Mrs B was diagnosed with moderate dementia caused by small strokes. This affected her balance and her memory. Mrs B's renal function also deteriorated in 2001 and she became increasingly physically dependent. In March 2001, a nephrologist and consultant physician at the hospital reviewed Mrs B and concurred with Dr C's findings and management of her symptoms.

Mrs B had been living with her daughter, Ms A. However, Ms A worked full time and was finding looking after her mother increasingly difficult owing to her deteriorating health. On 30 July 2001 Ms A and her brother consulted their mother's general practitioner, Dr C, and discussed her future care.

It was agreed that Mrs B should be admitted into a rest home for respite care with a view to long-term care. Dr C referred Mrs B to the hospital's geriatric services for an urgent assessment of her support needs level (SNL). An SNL determines the level of care residents require and is mandatory if accessing long-term residential care. Dr C advised me that at the time of requiring rest home care, Mrs B had become very frail with terminal heart and renal disease and moderate dementia. His referral letter to the hospital, dated 30 July 2001, stated:

> "Would you kindly arrange a SNL on the above. She quite urgently requires care and needs full assessment. … The family are currently assessing possible rest home and would appreciate an assessment done quickly."

Dr C gave Mrs B's family a list of rest homes to view. The rest home was not on the list, but the family chose it because of its proximity to one of Mrs B's sons and because the bedroom had the convenience of its own toilet. Mrs B's family visited the rest home two or three times and met with Mr G and Mrs D prior to Mrs B's admission. Ms A telephoned Dr C and informed him that the family was moving Mrs B into the rest home on Sunday 2 August 2001 for 28 days' respite care. However, her family hoped that she would settle and stay long term.

Mr G advised me that he was aware that the family were looking to settle Mrs B for the long term, but that Mrs B had difficulty in settling into the rest home and "nothing the staff did for her was satisfactory". She was emotional, frequently crying out during the night and day. She often asked why her family had put her there and required a lot of reassurance and attention. Mrs B was preoccupied with thoughts of lawyers and money issues. Her appetite was poor and she was difficult to please as regards her food. She often cried at meal times. Mr G stated that, in his view, Mrs B's dementia was "advanced" and that her memory was poor and worse than her family realised.

Mr G advised me that Mrs E saw Mrs B soon after her admission. Her initial impression was that Mrs B "was a very sick lady, and should have been admitted to [a] private hospital and not [a] rest home". Mrs E recalled that she saw Mrs B only "from a distance" and thought that she was a frail looking lady.

Mrs B's family were supportive and visited her regularly. However, despite this, she remained unsettled. From 7 to 16 August the following comments are recorded in Mrs B's progress notes: "… awake at times during the night … A little teary during the night …

miserable – finding it very difficult to be away from the family … a wakeful night … looking very weary today … another wakeful night." On 17 August "sleep pattern slowly improving" was recorded and on 18 August "did not sleep well. Quite unsettled and upset."

Mr G stated:

> "We believe [Mrs B] was reluctant to move into the residential facility, as she enjoyed home environment and constant attentions from the family. In some instances, the old people do not like being in the rest home and are reluctantly admitted to the rest home by the family for various reasons. These residents usually make rest homes look bad and sometimes complain for no reason. And if the resident is confused and forgetful the situation can be worse."

Management of Mrs B

From 2 to 9 August Mrs B's medical condition was stable, aside from a productive cough. On 10 August Mrs B told her daughter that she had fallen in her room. Ms A questioned Mr G about her mother's fall but was told that there was "no record" of her mother falling, and that the staff had not witnessed the fall. Mr G advised me that the night nurse had heard Mrs B call "[her daughter's name]" from her room. When she went into Mrs B's room the night nurse found her sitting on the toilet. Mrs B told her that she had fallen. The nurse examined her but there were no visible signs of injury. She did not complete an incident report or make a record in Mrs B's notes.

Mr G advised that in light of Ms A's concern he asked Mrs D to assess Mrs B. Mrs D did not see any evidence of injury or discomfort. She did not record her examination of Mrs B in the progress notes.

Saturday 11 August

On Saturday 11 August Ms A took her mother to Dr C's surgery, where they saw his partner, Dr H. Dr H noted that Mrs B had a painful sacrum, which was restricting her movement. She had oedema (excess fluid caused by her congestive heart failure) in her lower legs. He prescribed an analgesic for her back pain and increased her dosage of frusemide (a medication that assists with the excretion of excess fluid via the urine.)

Monday 13 August

Dr C reviewed Mrs B's condition at the rest home on 13 August and diagnosed a probable fractured coccyx, as a result of her earlier fall. He noted that she was "bright, nil distress" but had a moderate-sized shallow laceration to her left leg. He advised me that he had been told by Mr G that this had been caused by her shoe, when she had crossed one leg over the other. Mr G also told Dr C that Mrs B had been found sitting beside her bed, which she had apparently slipped off, and was now complaining of pain in her coccyx. Dr C advised that this is the only fall that he was aware of Mrs B having at the rest home.

He documented the following problems:

"1. NYHA class 4 CHF – slowly progressive
2. C&F creatinine 0.17 – small kidneys
3. Severe osteoporosis – on Alendronate
4. Pacemaker 2° to AVN dissociation

5. Fall 8.8.01 – clinically coccyx #
6. Tophaecous gout
7. Cerebrovascular dementia (lacunar infarcts CT scan)
8. Shallow area ulceration R calf with cellulitis
9. Recent URTI – on Amoxil
10. Reactive depression (leaving home)."

Dr C prescribed further analgesics for her coccyx pain and further increased her frusemide. He documented that she should have weekly blood tests, and be weighed every second day, with the results to be telephoned to him on 17 August, four days later. If her weight fell below 44kg he wanted to be notified. Mr G undertook to telephone Mrs B's results through to Dr C.

14 August
On 14 August Mr I, a nurse from the hospital, assessed Mrs B at the rest home, in response to Dr C's referral of 30 July. He noted that Mrs B was a respite care patient and that there was concern that she was at risk at home as she was on her own during the day. Therefore, rest home care was being considered on a long-term basis. Mr I recorded the following:

> "Functional ability – [Mrs B] is able to attend to simple personal care activities that include dressing and undressing with supervision. She requires assistance for showering. She is able to mobilise with the use of a stick. In an unfamiliar environment she requires direct supervision and assistance due to confusion.
>
> Recommendation – In my opinion, [Mrs B] is significantly dependent for personal care."

Mr I advised Mr G that he considered Mrs B to be SNL3. SNL 2, 3 or 4 indicates rest home level care is appropriate; SNL 5 indicates private hospital level care is required. Mr I arranged to review Mrs B in a further two to three weeks, to obtain a more accurate assessment of her condition. Mrs E advised that in her view there was an "ongoing problem" with assessment teams under-categorising residents (for funding purposes). In her opinion Mrs B was probably SNL 4 when she came into the home and quickly deteriorated to SNL 5 over a two-week period.

On the evening of 14 August Mrs B complained to Ms A of falling again, this time from her bed. There is no record of this fall.

15 August
On 15 August Ms A's brother visited his mother and was told that she had fallen from a chair. His mother was in a wheelchair in the kitchen with Mr G, who was "keeping an eye on her".

Friday 17 August
On 17 August Mrs D recorded the following in Mrs B's progress notes: "Walked unaided from her chair to her bed and slipped onto floor. Sustained skintear to lower R) leg." Mrs B and her aunt visited Mrs B and took her out in the car for a drive but returned with her half an hour later as she was complaining of a "sore bottom" and was in "agony, agony,

agony". Ms A telephoned Dr C and asked him to visit her mother as she was concerned that the "situation was getting worse".

Dr C visited at approximately 9.00pm that evening. He examined Mrs B and noted that while her pain control was much improved, her mobility had deteriorated. She was now unable to sit upright unaided or walk, and was incontinent of urine. He thought Mrs B was probably now "SNL 4 or SNL 5 borderline".

Dr C recorded the following:

> "Poor mobility in spite of no/minimal pain
> coccyx … (illegible) Distressed night behaviour – calling out
> Good diuresis 50 → 46kg ↑ incontinent of urine
> Says she fell out of bed x1 … (illegible) leg leaking oedema fluid. Bloods ok
> OE: lucid; very weak + frail; sinus 72
> IVP + 5 chest clear
> Oedema++ legs (albumin 29)
> For 1) further snl assessment
> 2) msu
> 3) Same diuretics – notify me if once 44kg
> 4) Zoltabs 7.5mg ½ nocte."

Mrs B told Dr C that she was having falls and Ms A explained that her mother was frightened of falling out of bed. He spoke to Mr G and asked if bed rails were available. Mr G told him that as the rest home was not a private hospital, they did not have that sort of equipment; the only solution was to wedge a pillow between the mattress and base.

Dr C concluded that an admission to a public hospital that evening was inappropriate, as the hospital would be reluctant to admit Mrs B at that time of night unless she had an acute medical need. Instead, he discussed with Ms A the option of transferring her mother to a private hospital. However, prior to a transfer Mrs B would need to be reassessed by a geriatrician for an SNL. As this was unable to be completed over the weekend he said he would arrange for an urgent reassessment on Monday.

After Dr C left, Ms A and her aunt, Mrs F, assisted a caregiver to change Mrs B's nappy. Mrs F was facing Mrs B and supported her upper body while the caregiver cleaned Mrs B's bottom. Ms A was standing behind her mother steadying the wheelchair and saw that her mother's buttocks were red "like sunburn" in a circle. The skin was not broken and there were no blisters. She made no comment at the time as she was feeling overwhelmed with bad flu, and was concerned by her mother's recent complaint of being slapped by a caregiver and being frightened of falling out of bed.

Admission to the hospital

On Saturday 18 August Mrs B had an unobserved fall, sustaining a deep skin tear to her left lower leg. Mr G was advised of the fall and an incident form was completed by a caregiver, but an account from Mrs B about how she fell was not recorded. The fall was not recorded in Mrs B's progress notes.

Ms A and Mrs F called in to see Mrs B in the late morning but stayed only briefly as "the rest home did not like visits from families during the lunch break". They returned in the early afternoon and were concerned about Mrs B's condition. She was vomiting and complaining of pain, and was unable to keep down her pain relief medication. Ms A telephoned the on-call nurse, Mrs E, and said that she wanted to take her mother to the hospital. Mrs E recalled that she suggested an ambulance transfer, but Ms A elected to take her mother in her car. A caregiver assisted with transferring Mrs B into the car. They arrived at the hospital at approximately 3.30pm. Ms A stated:

> "On leaving the retirement home on 18 August 2001, to be admitted to [the public hospital], [Mrs B] could not walk, stand or sit up unassisted and was incontinent, not being able to walk to the toilet. She had abrasions to both lower legs and had bruising. Her bottom was burnt red from urine scalding. She was in agony."

Ms A advised that the medical staff at the hospital asked her what medications her mother was on. She was unable to get through to Mr G, so she telephoned Dr C at his home at approximately 10.00pm. She stated that Dr C sounded surprised to hear of her mother's admission. He supplied the names of the medications Mrs B was on.

The admitting staff recorded that Mrs B had skin lacerations to both lower legs, and pulmonary oedema (lungs filled with fluid). She was alert and orientated, but nursing staff recorded that she was "agitated, anxious to get to ward, crying out". At 10.15pm nursing staff recorded that she was wearing an incontinence pad and "buttock + groin area excoriated++ and red raw. Small ? pressure sore on left hip noted also."

The following morning the nursing records stated:

> "Pt [patient] was admitted to ward early hours of mane [morning]. Pt constantly dribbling urine, bladder distended query retention [with] over flow → therefore IDC [indwelling catheter] inserted and drained 700mls. Pt's perineal + buttocks area inflamed to the point of bleeding → query secondary to urine burns. … Pt extremely noisy and disruptive therefore nursed in f/over bay to avoid disrupting other patients. 2x bandages on pts lower legs one on each leg. Pt given small sips of H_2O [water]. Pt needs to be referred to SLT [speech language therapist] as pt has difficulty swallowing."

Mrs B was reviewed by the medical team, who noted her presenting history of falls, confusion and worsening of her congestive heart failure. She was assessed as having ischaemic CM [cardiomyopathy], being undernourished and immobile, having skin tears, a history of strokes and chronic renal failure. Mrs B's condition continued to deteriorate and she died a few days later.

Autopsy
A pathologist performed an autopsy on Mrs B. She noted the following:

> "…
>
> Marks of injury:

An area of bruising was present involving the right upper eyelid. A small area of bruising was present on the cheek. Multiple small areas of bruising was present on the forearms and lower limbs. A 10 x 6cm area of bruising was present on the right lower posterior chest wall. A flap laceration was present on the medial aspect of the left lower shin which had been closed with steristrips. A severe perineal rash was present.

Comment
Postmortem examination demonstrated a number of findings including ischaemic heart disease, chronic respiratory disease and cerebrovascular disease. A perineal rash was present and was consistent with being due to contact with urine. A number of bruises were present on the face and limbs which were consistent with having been received as a result of a number of falls. The immediate cause of death is most likely to be ischaemic heart disease."

Nursing assessment/care planning
Mr G recalled that he gave Mrs B the rest home's Admission Form and a Resident's Information Form. However, the forms were never returned by the family, despite him asking for them. The Resident's Information Form detailed basic information about the resident's "likes and dislikes, important social and medical information". Mr G stated that, without this information, the rest home had insufficient information to implement their in-house care plan process and medication administration.

Ms A confirmed that the family did not return the forms, as they were concerned that if they did so, the rest home would claim payment for the entire 28 days even if Mrs B did not stay that long.

Mrs B's family gave Mr G a list of contact names and telephone numbers and a week's supply of medication, which he prepared into a blister pack. Mr G recalled that no medical information accompanied Mrs B, and none was forthcoming until Dr C's visit on 13 August. However, Ms A advised that she also gave Mr G a medication chart, supplied by Dr C, to assist with her mother's medical management.

As Mrs D did not work weekends she did not see Mrs B until Monday morning, the day after her admission. Mrs D could not recall her first meeting with Mrs B, but did not think that she had any particular medical concerns about her. Mrs D recorded in the progress notes that Mrs B had not slept well on the Sunday night and "has not settled well". Other than some dry skin patches on her legs, no mention is made of any medical or nursing concerns. Mrs B required a lot of reassurance and was "apprehensive and confused".

Mrs D advised me that she considered that Mrs B's dementia did not require any special management, as the rest home had other residents who were similarly confused. Mrs D's usual practice with new residents involved going through the rest home information with them and discussing the responsibilities of the rest home and the resident. Generally, she saw her role as assisting with getting the resident settled and oriented to the home and staff.

The form "6.0 What to do when admitting a new resident" (Appendix 1) dated 14 August 1999 describes the steps necessary to orientate a new resident, and requires staff to make up a doctor's file, order necessary drugs, complete the medication box, fill out a drug sheet

and signing list for medication and "notify the relevant surgery that the resident is admitted into the R/H and ask them if they can send the medical notes to the R/H".

The "Resident Admission Checklist" (Appendix 2) states that the "RN and medical staff will provide a medical review of each new resident within 48 hours of admission", and "Resident profile, assessment and care plan will be documented within 24 hours (defi[nitely] with three days) of the admission". A flow chart (Appendix 3) reiterates the above process to be followed when admitting a new resident. Another form, "Complete on admission and every 3 to 4 months" (Appendix 4) details residents' needs in respect to "health assessment", "participation in social activities", and personal cares such as eating, breathing, toileting, bathing, dressing and moving about.

The policy on Care Plans, dated 14 August 1999 (Appendix 5) states that individualised residents' care plans "are essential to the provision of client centred care. They allow for continuity of care, by-pass constant repetition of verbal instruction and facilitate communication between staff." The policy states that on admission a nursing assessment is "filled in" and a short-term care plan developed until a more comprehensive plan is developed in one to two weeks' time. The policy states that "nursing staff" are expected to inform management if they feel that a care plan is not up to date or if the resident's need for care has changed. The "nursing manager or her designate" is responsible for reviewing and updating care plans.

The Short Term Plan (Appendix 6) covers areas such as hygiene and dressing, mobility and risk of falls, pressure area care, communication, sight and hearing, diet and fluid requirements, social and recreational needs, and special needs and instructions, and is signed off by the registered nurse.

A care plan was not developed for Mrs B during her stay, and a nursing assessment is not recorded. Mr G advised that at the time of Mrs B's admission it was not the rest home's practice to complete care plans for short-stay residents; they were completed for long-stay residents only. The policy has since been amended to include care plans for short-stay residents. The form for the short-stay care plan remains the same as was already in place, but it now specifies that it should be used for short-stay residents. Mrs D advised that she would now conduct a nursing assessment for a respite patient because the policy has been changed to make this a requirement.

Liaison between Dr C and the rest home

Mr G advised that Mrs B's family preferred to use their own doctor, Dr C, instead of the rest home's doctor. The family took responsibility for taking Mrs B to the doctor and at times the rest home was not aware of those visits. Prior to Dr C's visit on 13 August 2001, Mrs B's medical records were kept at the doctor's surgery and were not available to the rest home. Mrs B's family conveyed instructions from Dr C to the rest home.

Mrs D stated that although she was aware that no medical/clinical information had accompanied Mrs B, her understanding was that Mr G had requested the notes, but that "they took a long time to arrive". However, Mr G stated that he did not request Mrs B's medical notes prior to her admission, as this was not part of the rest home's standard procedure. Furthermore, he advised that "families get confused if lots of paper work is

thrown at them". Since this incident the rest home's procedure has been amended and doctors are now required to supply notes and discuss the patient either with Mr G or Mrs D.

Mr G stated that it was his understanding that Dr C was assuming "full responsibility" for Mrs B's care while she was in the rest home. He advised:

> "It is inappropriate to blame the rest home for the failure of not recognising [Mrs B's] deteriorating medical conditions and mobility. The family, by their own choice, was responsible for the visit to surgery and medication supplies charted by doctor. We had no information of any details, reports of [Mrs B's] condition or medication charting until 13 August 2001. [The] only information given to us was the medications and verbal or written instructions on a piece of paper from the family. The rest home staff used residents' progress notes from registered nurse and caregiver's observation and information supplied by the family for her care giving."

Mrs E advised that the rest home preferred doctors to come to the home to see the resident and then document their visit in the notes. Because of the arrangement between Dr C and the family, this did not happen until 13 August. In her view, respite care was a difficult area to manage, particularly in terms of getting medical notes. She stated that Ms A "controlled" her mother's medications and doctor's visits and it was therefore "difficult to get past her". Ms A would not sign the visitor's book and "would just arrive and take her mother out ".

Mr G advised that despite these difficulties, Dr C tried to keep him included and, particularly after the visit of 13 August, he and Dr C discussed Mrs B's condition several times on the telephone and when Dr C visited.

Falls

Mr G disputed that Mrs B had had "several falls" at the rest home, or that she had ever fallen out of bed. Mr G questioned whether, in light of Mrs B's dementia, the falls she complained of occurred at the rest home or at her own home prior to her admission. He commented that if Mrs B had had a number of falls they would have resulted in fractures, as she had severe osteoporosis. Mr G was aware of only one fall occurring, on 17 August. However, he was aware that Mrs B sustained a skin tear on the morning of her admission to the hospital (18 August). He was unsure how the skin tear occurred, but as there was marked oedema in her lower legs he thought it was possible that her skin had torn by the back heels of her slippers while crossing her legs.

Mr G commented that the staff knew Mrs B had a history of falls but that it was nonetheless difficult to predict falls in the frail elderly. He stated: "We have to allow freedom for the residents to move about, as that is their right. … It is not practicable to monitor 24-hours a day all residents without compromising their freedom."

Mr G advised that "minor incidents and accidents are fully investigated, but not reported into the Incident Book where the incidents were not observed and there was no injury sustained. This avoids recording any incidents that may not have occurred."

The rest home's incident policy (Appendix 7) states:

> "All incidents and accidents are to be reported to the manager and/or RN. It is the responsibility of the manager or RN to document the incidents and the treatment provided in the 'Incident Accident Register' located in the Office. … At the end of each month the forms are analysed and compiled."

An incident is defined as anything that makes a resident "unhealthy or unhappy", such as skin tears, infections, falls, fractures, fights, etc.

Urinary incontinence management

Mr G advised that Mrs B's dosage of diuretic medication was increased to reduce her fluid retention. This resulted in an increased urine output, which meant that Mrs B was unable to make it to the toilet on time. He advised that the following practices were in place:

> "Two hourly toileting and hygiene whenever necessary. In worse situation we recommend use of incontinence aid such as incontinent pads, incontinent pants etc. These aids are designed to minimise skin urine burns. Regular change and hygienic cleaning and reuse if they are reusable."

The policy on managing continence states: "Residents will be assisted with maintaining a normal lifestyle by the management of incontinence through the development of individualised continence management plans on admission and at regular intervals in order to promote dignity." The policy also states: "… the care staff will record and report incidents of continence as well as incontinence … in order to develop a continence management plan", and "… the RN is responsible for identifying which product will be most effective as part of the continence assessment. This information will be documented in the residents care plan in order to inform all staff directly involved in the care of the resident."

The policy recommends regular review of the continence plan and products to assess "the maintenance of their skin, hygiene and dignity".

Mr G suggested to Mrs B's son that incontinence pants could be purchased so she did not have to rush to the toilet. The rest home commenced using incontinence pants from their own stock on the understanding that family would pay for them. Mrs D advised that residents wore incontinence pants only during the day. At night-time, the bed was covered with a "kylie" (an incontinence draw-sheet). Incontinence pads were not used by the rest home as they held urine close to the skin (which can damage the skin). Mrs D could not recall Mrs B complaining of pain on her bottom but had noted that her sacral area was red and she was getting the staff to put Ungvita on it.

Mrs E stated that she did not consider Mrs B's urinary incontinence to be an uncommon problem as several residents had urinary incontinence. Nor did she consider the amount of urine that Mrs B passed as "excessive" given she was in renal failure. Mrs E stated: "Things wear out, skin tone wears out", and commented that "family have a problem letting loved ones go".

Mr G advised that the urine burns that the hospital observed on 18 August were "a form of ammonia dermatitis", which develops if a resident does not take an adequate amount of fluids because of not being able to get to the toilet in time. Consequently, the urine

becomes very concentrated. He disputes that Mrs B developed urine burns as a result of the rest home's management. Mr G advised that when Mrs B's family removed her from the rest home on 18 August, they discarded her incontinence pants and requested a pad from the caregivers. Mr G commented that, given her increased urine output caused by the frusemide, it would not take long before the pad was saturated with urine, which could have set up the dermatitis in a relatively short time.

> "Depending on the factors such as urinary tract infection, concentration of urine and/or length of time between toileting and changing, it is possible that one or more of the factors may have contributed to such burns. We have no knowledge of what could have happened [Mrs B] following her transfer from rest home to the hospital and time elapsed before the medical team saw her."

Ms A advised that when she arrived on 18 August her mother was still lying in bed, as she was too sick to get up. She helped her mother to dress and noticed that she was not wearing incontinence pants. Instead, she was wearing an incontinence pad in her underpants. Ms A said that she did not remove or change the pad. Mrs B's sister, Mrs F, was also present but could not recall what incontinence product Mrs B was wearing that morning. Mrs F denied that either she or Ms A had put a pad on Mrs B, as this was not something they carried with them. She thinks that a caregiver placed a pad in Mrs B's underwear. In response to my provisional opinion Ms A concurred with Mrs F's statement that a caregiver placed a pad in her mother's underwear.

Transfer to hospital

Mr G accepts that when a resident's care needs are beyond what the rest home can provide, the resident should be transferred to another facility. However, this is not a decision made by the rest home; rather, the rest home is guided by the advice of the medical practitioner and family. Mr G advised that the family were given "three options" in regard to Mrs B: "send her to hospital, keep her in the rest home, send her to [a hospice]. Dr C and the family decided to keep her in the rest home." However, Ms A stated that the only option presented to her was transferring her mother to a private hospital.

Assault

Mrs B complained to her daughter that a caregiver had struck her across the face and that caregivers were rough to her, although not when family were present. There were no witnesses to an assault but Ms A believes her mother's account.

Mr G denied that any of his staff had assaulted Mrs B and said that the allegation was not brought to his attention. He commented as follows about his staff:

> "They are caring, gentle and willing to help in any situation. In over ten years in business with [the rest home], we have never had any reported incidents of physical abuse and after talking to staff, they have told me that none of them had physically abused [Mrs B]."

Documentation

The progress notes, recorded by Mrs D during the period that Mrs B was a resident at the rest home, do not describe her deteriorating medical condition. Despite Mrs B's falls and changing medical condition there is only one reference, on 18 August, to "condition

deteriorating". On 6 August Mrs B is recorded as having a "troubling cough"; however, "condition slowly improving" is recorded on 16 August and "sleep pattern very slowly improving" is recorded on 17 August.

The only reference in the progress notes to Mrs B's urinary incontinence is "HPU [has passed urine]" on 15 and 16 August. The amount of urine, Mrs B's fluid intake, and the method of managing her incontinence is not recorded. There is no record of Mrs B having a perineal rash or complaining of pain.

Mr G made the following comment in relation to the standard of documentation: "We cannot see that there has been any professional neglect in the period of time [Mrs B] was in our care. We have kept full and accurate patient records, copy attached." Mrs D commented that while she would not change the care Mrs B was given if the situation was repeated, she would document more clearly, particularly the progress notes. Mrs D advised that she now records very full progress notes, which better describe the care given.

Dr C

Dr C rejects any suggestion that he did not recognise that Mrs B's condition was deteriorating. He advised that he thoroughly assessed her each time he visited and, when he felt she needed private hospital level care, he arranged for her to be reassessed as soon as possible.

Dr C noted that he wrote thorough notes following his examination of Mrs B on 13 August and discussed her management with Mr G. When he examined Mrs B on 17 August he noted her deterioration and agreed with family that she needed a higher level of nursing care. He arranged for her to be urgently reassessed for private hospital care following the weekend. He recalled:

> "I did not admit her that night to the hospital because they would not, in my experience, accept a patient under the acute medical service for nursing care only, when no acute medical interventions were indicated or required."

Ministry of Health Audit

In response to Ms A's complaint the Ministry of Health made an unannounced visit to the rest home on 27 September 2001. Mr G advised the Ministry of Health that because Mrs B's family retained control over their mother's medical consultations and supply of medications he had absolved himself of responsibility for the matter. Without medical information he found it difficult to plan care for Mrs B.

The Ministry of Health noted the following concerns in respect to the lack of care plan and nursing assessment:

> "It is of concern that [Mrs B] had been accommodated at the rest home for a total of 16 days and there is no record of any assessment being undertaken for her or a care plan developed by senior staff or the registered nurse. Even though the manager has stated that he and staff encountered difficulty in undertaking this with the family taking over their mother's ongoing medical care and treatment, and that he absolved this responsibility to the family, the fact remains, that the licensee and the manager are responsible for the care to any resident whilst they are accommodated at the Home.

> Despite any difficulties encountered, it would be expected that the manager ensure adequate assessments are undertaken at the time of a resident's admission and as required, and, that appropriate documentation is maintained in a timely manner. This should apply equally to residents accommodated for the long-term and for respite care. If the assessment and care plan forms that are currently in use at the rest home are not appropriate for use with respite care residents, then alternative forms should be developed. A lack of documentation for the assessment and treatment and care of a resident can compromise safety and well being for that resident."

The Ministry of Health advised that the manager of the rest home said that the policies and procedures followed and the forms used for people admitted for short-stay care were the same for any other resident being admitted to the rest home. The only difference was that the care plan was not so comprehensive or extensive for short-stay residents.

Independent advice to Commissioner

General practitioner advice
The following expert advice was obtained from Dr Tessa Turnbull, a general practitioner with a special interest in the care of the elderly.

> "'To assist the Commissioner form an opinion on whether [Dr C] and [the rest home] exercised reasonable care and skill in providing services to [Mrs B].'
>
> **Supporting Information:**
>
> - 'A': Letter [Ms A] to the Commissioner
> - 'B': [Dr C] to the Commissioner
> - 'C': [The rest home's] response
> - 'D': Ministry of Health report
> - 'E': [The public hospital's] medical records for [Mrs B]
> - 'F': Consultation notes from [Dr H]
>
> **Background**
>
> **Social and medical history:**
> [Dr C] was [Mrs B's] GP from 1996. Between 1996 and 2001, [Mrs B's] health gradually failed and [Dr C] saw her between 10 and 20 times a year to manage her various medical problems. [The nephrologist and consultant physician] reviewed her in March 2001 and concurred with [Dr C's] findings and management. The major ones were:
>
> 1. ischaemic heart disease, hypertension, controlled heart failure and a pacemaker. Medication was captopril 25mg, frusemide 160mg, aspirin.
> 2. osteoporosis and associated fractures, on alendronate and calcium.
> 3. chronic renal failure
> 4. gout

5. dementia due to previous strokes as shown in a CT of her brain in 1996. The outward manifestation of this was memory loss and poor balance leading to falls.

[Mrs B], now aged 78, was admitted to [the rest home] for respite care on 2/8/2001 after she and her family had discussed this with [Dr C] on 30/7/01. She had been living at home with her daughter [Ms A]. She had been assessed as support needs level 3 at the time of her admission to [the rest home] and was admitted for 4 weeks' respite care with consideration of long-term placement. [Dr C] asked for an urgent SNL assessment on 30/7/01 and this was actioned on 14/8/01.

[Mrs B] was mobile with a walking stick but needed assistance to dress and shower at the time of her admission to [the rest home]. Her health rapidly deteriorated after an unwitnessed and undocumented fall on 10/8/01.

She was admitted to [the hospital] on 18/8/01, at which time she could not walk, stand or sit up unassisted and was incontinent. She had abrasions to both lower legs and bruising. She had severe buttock and perineal excoriation.

History at [the rest home]:
2/8/01: [Mrs B] admitted to [the rest home]

9 or 10/8/01: fall – There are no official records of this and conflicting accounts between that told by [Mrs B] to her family and that documented by [Mr G] in his letter to the Commissioner 21/10/01. He says that there were no documented injuries but the lower back injury was apparent to [Dr H] on 11/8/01.

11/8/01: [Mrs B] seen by [Dr H] at … Clinic. His notes record worsening of [Mrs B's] known heart failure, sacral pain and local tenderness due to a fall two days previously and associated poor mobility. He increased the frusemide to control the heart failure, gave antibiotics and provided pain relief.

13/8/01: [Mrs B] seen by [Dr C] at [the rest home]. [Dr C] said that she was bright, lucid and undistressed. She had a moderate but shallow laceration on her right lower leg. Mr G told him that this had been sustained by the heel of her shoe. She had also been found by her bed and was complaining of coccygeal pain. [Dr C] felt she had fractured her coccyx, discussed her medical problems with [Mr G] and wrote extensive medical notes and instructions for the rest home ie to be weighed every second day and weights telephoned to him.

14/8/01: [Mrs B] assessed by [Mr I], a gerontology nurse practitioner. He records [Mrs B] as being significantly dependent for personal care but able to dress and undress with assistance but needing supervision with showering. He recommended long term rest home care.

17/8/01: [Mr G] said [Mrs B] was seen to fall. [Dr C] visited [Mrs B]. He felt her pain control was good but her mobility had suddenly worsened, she needed support to walk. He examined the coccygeal region and did not notice the excoriation reported the following day. She was having more disturbed nights and had become more incontinent of urine, probably because of her increased diuretic treatment. He felt that

reclassification to 4/5 SNL was appropriate but this would need geriatrician approval which he would initiate after the weekend. He again wrote up full notes. The progress notes record a fall and a skin tear on the right lower leg on the 17/8 but an incident record the next day records this as the left lower leg.

18/8/01 [Ms A] took [Mrs B] to [the hospital] by car where she was admitted.

Ministry of Health Investigation:

This consisted of an unannounced visit on 27/9/01 by two review officers. A review of the documentation relating to [Mrs B] and relevant to the day-to-day care for residents was undertaken.

Conclusion and recommendations:

1. There was no nursing assessment or care plan undertaken during [Mrs B's] residency and progress notes were sparse.

The admission form to be completed by the family was apparently not returned to the manager. The manager stated that he did not receive any notes on [Mrs B's] previous history or written instructions regarding her care and management. The manager said that the family wanted to be responsible for [Mrs B's] medical consultation and supply of medication. The manager said he therefore absolved himself from responsibility of medical care needs, planning or active intervention. The manager stated that he insisted that [Dr C] complete a medication profile on 13/8/01, medical notes were provided at this visit on 13/8/01.

The conclusion of the review officers was that the licensee and manager are responsible for the care for any resident while they are accommodated at the rest home. 'Despite any difficulties encountered, it would be expected that the manager ensures adequate assessments are undertaken at the time of the resident's admission and as required and that appropriate documentation is maintained in a timely manner. This should apply equally to residents accommodated for long-term care and for respite care'. 'A lack of documentation for the assessment and treatment and care of a resident can compromise safety and well being for that resident.'

2. A review of the incident/accident register and associated policies showed the policies to be acceptable except that of only notifying residents' relatives if the accidents 'are potentially serious or result in serious harm, or if the manager believes they are warranted'.

In fact, the two falls reported by [Mrs B] to her daughter, and recorded by [Dr C] and the registered nurse are not recorded in the incident/accident register.

3. Staff cover is above the required minimum number of hours but staff hours worked are longer than ideal.

4. Policies and procedures were kept in a locked office when the manager was absent from the home.

5. There were conflicting policies on the provision of continence aids.

6. There were no management of pain guidelines.

[The hospital] admission:
Acute problems:

1. poorly controlled heart failure
2. renal impairment
3. skin lacerations to both lower legs
4. back pain controlled by morphine
5. agitation, confusion and anxiety
6. urinary incontinence, retention and overflow
7. perineal and buttock inflammation/ excoriation

Over the next few days, [Mrs B] developed swallowing problems, hypotension, difficulties with fluid balance and control of the heart failure. She died [a few days later].

Autopsy Report:
Bruising on the face, limbs and chest. Flap laceration left lower shin. Severe perineal rash consistent with prolonged contact with urine. The immediate cause of death is most likely to be due to ischaemic heart disease.

What specific professional and other relevant standards apply in this case and did [Dr C] and [the rest home] meet those standards?

The standards are those of professional competence of the GP, particularly in understanding and managing the care of older people. There is an associated responsibility of the rest home/hospital to have its own accreditation and to liaise with the doctor appropriately so that both work compatibly in partnership.

[Dr C] is a Fellow of the RNZCGP ie a vocationally registered GP. Although not detailed, I assume he is undertaking ongoing study/education/peer review to both ensure a current annual practising certificate and for his own interest and competence.

[The rest home] received a Telarc Q-Base registration certificate in September 1999 which meant that it had been found to operate a quality management system complying with the requirements of the Telarc Q-Base Code. This is a very basic quality assessment measure but it shows willingness on the part of the rest home to look at some very basic quality improvement.

The Ministry of Health audit after the complaint had been received showed some reasonably severe deficiencies at [the rest home] which impacted directly on [Mrs B's] care ie

Conclusion and recommendations:

1. There was no nursing assessment or care plan undertaken during [Mrs B's] residency and progress notes were sparse.

2. A review of the incident/accident register and associated policies showed the policies to be acceptable except that of only notifying residents' relatives if the accidents 'are potentially serious or result in serious harm, or if the manager believes they are warranted'. In fact, the two falls reported by [Mrs B] to her daughter, and recorded by [Dr C] and the registered nurse are not recorded in the incident/accident register.

3. Staff cover is above the required minimum number of hours but staff hours worked are longer than ideal.

4. Policies and procedures were kept in a locked office when the manager was absent from the home.

5. There were conflicting policies on the provision of continence aids.

6. There were no management of pain guidelines.

Of these deficiencies, the first two are the serious ones. The review officers state that the licensee and manager are responsible for the care of any resident while they are accommodated at the rest home.

[Mr G] failed to ensure the information he required was returned from the family and this meant that there was no nursing assessment or care plan undertaken during [Mrs B's] residency.

Furthermore, the two clear accidents relating to [Mrs B] were not documented and the stated policy was contradictory and unsatisfactory. This shows sloppy practice on the part of [the rest home].

The review officers state: 'A lack of documentation for the assessment and treatment and care of a resident can compromise safety and well being for that resident.' [Mrs B] deteriorated very rapidly after her fall. She was prone to falls and the cascade of health events is likely to have occurred regardless. Nevertheless, these omissions show [the rest home] in a poor light.

Comment on the liaison between [the rest home] and [Dr C]. Was this adequate?

No, it was not. At the time [Dr C] saw [Mrs B] on 30/7/01, her medical problems, although brittle, were relatively stable and it was largely the social situation which prompted her admission for respite care.

The family instituted the next medical consultation as a result of their concern, taking [Mrs B] to the after hours doctor on Saturday 11/8/01. At that time she was starting to show the effects of her undocumented fall and was starting to slip into uncontrolled heart failure.

It seems [Dr C] visited [Mrs B] at [the rest home] as a follow-up to this visit ie [the rest home] was distant to the process. This certainly highlights the lack of a care plan and good progress notes.

From this point, medical notes were undertaken and [Dr C] carefully followed through his management plan. It was confounded to some extent by further and serious deterioration the following days. [Mrs B] had moved from a SNL 3 on admission to a 4/5 by Friday 17/8/01. On Saturday 18/8/01, there was significant further change and the family decided to independently take [Mrs B] to the hospital themselves.

Was [Mrs B's] deteriorating medical condition and mobility managed appropriately by [Dr C] and [the rest home]? In particular, comment on the preventive measures put in place at the rest home to prevent [Mrs B] falling.

I think [Dr C's] management of [Mrs B] was very appropriate at all times. His overall management is backed by [the nephrologist and consultant physician] and gerontology nurse [Mr I]. I have some concerns about [the rest home's] general management as expressed above. However, their policy about cot-sides was quite transparent and cot-sides have their own problems and have to [be] managed very carefully. Putting a pillow under the mattress is common practice and adequate under appropriate circumstances.

Was [the rest home's] documentation and management of [Mrs B's] fall risk adequate? In particular, should all falls be documented?

As mentioned, I think [the rest home's] documentation at all stages was sloppy or inadequate. A fall risk policy was not considered and certainly not documented in a care plan. All but the most minor falls should be formally documented and the family told of these at the time or soon after depending on the severity and timing of the fall.

Was [Mrs B's] incontinence managed appropriately by staff at [the rest home] and [Dr C]?

I think yes to this in spite of the Ministry of Health's comment on the conflicting policy regarding incontinence aids. [Mrs B's] incontinence was significantly affected by both her fall and by the medication required to be used for her worsening heart failure. It is a fine balance in these circumstances and the management seems appropriate.

[Mrs B's] rapid development of the perineal and buttock excoriation occurred from 17/8/01 (not apparent or very mild when viewed by [Dr C] on that date) and was undoubtedly caused by her incontinence and the antibiotics. These had been changed from amoxil to synermox, an antibiotic most likely to have this as a side effect.

[Mrs B's] rash certainly appears to have been severe on her admission to [the hospital] and was still present at the autopsy suggesting that the hospital had difficulty getting on top of this.

Was [Dr C's] referral for private hospital level care timely and appropriate?

When [Dr C] saw [Mrs B] on 17/8/01, he recognised the significant fall-off in her health status in the preceding week. She had many underlying and serious health problems. The heart failure was not stabilising despite the increase in her diuretic. Clinically, she had a fractured coccyx caused by her osteoporosis and the fall. She was

barely mobile and incontinent. This is a difficult set of circumstances and public hospitals do not like Friday afternoon admissions without a readily identifiable reversal of the problems. [Dr C] decided an urgent medical admission was not warranted on 17/8/01 and decided to initiate an urgent assessment for a new SNL on 20/8/01.

Are there any other relevant issues in relation to the standard of care provided to [Mrs B]?

I think they have all been covered.

To advise the Commissioner whether the GP and rest home services received by [Mrs B] were provided with reasonable care and skill.

[Dr C's] care of [Mrs B] was very adequate, I believe and I think the family accept this. In retrospect an admission on Friday night might have been justified but this is a hindsight statement.

[The rest home] has shown some sloppy, if not inadequate documentation, which may have had some impact on [Mrs B's] quality of life but probably not the actual outcome. [Mr G] said he absolved himself from responsibility of medical care needs, planning or active intervention because the family had taken on this responsibility. This was his responsibility by regulation and he should have been communicating and working with the family much more positively to support [Mrs B's] needs."

Nursing advice
The following independent expert advice to the Commissioner was provided by Ms Shirley Hughes, a registered nurse with expertise in care of the elderly:

"**Purpose**
To provide independent advice about whether [Mrs B] received an appropriate standard of care whilst a resident at [the rest home].

Background
[Mrs B] was admitted to [the rest home] for respite care. While there [Mrs B's] medical condition and mobility deteriorated. She was assessed as a Support Needs Level (SNL) 3, however soon after this her condition deteriorated. Her general practitioner arranged for an urgent reassessment. Before this could occur [Mrs B's] family admitted her into [the hospital], where she died [a few] days later.

Complaint
1. Despite [Mrs B] having several falls, no preventative measures were put into place and no bed rails were available.
2. [Mrs B's] fall on 10th August 2001 was not properly documented.
3. [Mrs B's] incontinence was not properly managed.
4. [The rest home] failed to recognise and manage [Mrs B's] deteriorating medical condition and mobility.
5. On 17th August 2001 [Mrs B] complained to her daughter that a staff member assaulted her on or about 16th August 2001.

6. Despite being alerted to [Mrs B's] deterioration by her family, [the rest home] failed to admit [Mrs B] to hospital. She died [a few] days later.
7. There was inadequate liaison between [the rest home] and [Dr C].
8. [Dr C] failed to recognise [Mrs B's] deteriorating medical condition and respond appropriately.
9. [Dr C] failed to get [Mrs B] promptly assessed for hospital level care.

Supporting Information

1. [Ms A's] letter of complaint marked 'A'
2. [Dr C's] response marked 'B'
3. [The rest home's] response and medical records marked 'C'
4. Ministry of Health report marked 'D'
5. [Mrs B's] medical records from [the hospital] marked 'E'
6. [Mrs B's] consultation notes from [Dr H] marked 'F'

Elderly people, particularly those who suffer any degree of dementia, are among the most vulnerable group of consumers within society. The rights of this group must be protected. Legislation and regulations provide guidelines from which standards are developed. Policies and protocols are developed by health care facilities which, if complied with, protect the resident and the staff. In my opinion [Mrs B] did not receive safe and adequate care while she was a resident at [the rest home].

Evidence which supports my opinion:

1. Expected standards

[The rest home] purport to be '*committed to providing Quality Care and Service, with an emphasis on maintaining a strong sense of dignity and independence, to residents with varying physical challenges …* believe *that our care and service must be delivered with compassion, professionalism and empathy and within the practice of Quality Assurance*' ([the rest home's] Philosophy).

Further, it is stated (Code of Residents Rights) that all residents have the right to '*expect a level of care consistent with their assessed care needs is provided*'.

The particulars in the request for an investigation by [Ms A] into the standard of care received by her mother are addressed within the following sub-sections.

2. Admission and assessment procedures

There is no evidence of an initial admission form being filled out. The manager of the Rest Home advised the Ministry of Health investigators that '*policy and procedures followed and the forms used for people admitted for respite care were the same as for any other resident admitted to the Home*'. ([The rest home's] Complaint Report pg 3 para 3.)

[The rest home's] Policy 6.0 '*What to do when admitting a new resident*' makes no differentiation between long-term and respite care residents. It must be noted that the [the rest home] policy on Care Plans Qan12.0 identifies that '*on admission a nursing*

assessment is filled in together with resident/resident/agent. Following 1-2 weeks of observation a more definitive care plan is filled in …' This policy was revised 14th August 2001. There is no documentation relating to the policy before 14th August, and no change to the policy at the revision 21st November 2001 following the investigation by the Ministry of Health Regional Licensing Office.

The Health and Disability Standards Service delivery Outcome 4 identifies that '*consumers/kiritaki receive* timely, *competent and appropriate service provision in order to meet their assessed needs, desired outcomes and goals*' (Standard 4.1). There is no evidence in the written documentation that any of the criteria (4.1.1-4.1.6) to achieve this outcome were undertaken.

There is
- no letter of referral from the doctor
- no admission document
- no assessment sheet
- no plan of care
- as there is no plan of care – any evaluation of [Mrs B's] ongoing condition would be difficult to effect

[Mr G], in his letter to [HDC] October 21st 2001, advised that '*she was a sick lady on admission with significant co-morbidity and increased dependency requiring increased personal care assistance'* also that '*soon after her admission [Mrs E] ... saw [Mrs B's son]. Her initial impression of her condition was that she was a very sick lady and should have been admitted to Private Hospital not Rest Home.*' None of the above is documented, nor is there any baseline assessment of [Mrs B] despite the concern.

The progress notes appear to commence 3-08-01, signed ERM, RN identified in the list of employees as [Mrs D]. The first notation in the progress notes states '*skin areas satis*'. There is no further report on the condition of [Mrs B's] skin in the progress notes, which conclude 18-08-01. There is no documentation relating to the urine burns.

The progress notes do identify [Mrs B's] confusion (3.08-0[1]), her cough (.08.0[1] and .08.0[1]).

Note: I am unable to discern the dates on the photocopy of the progress notes.

3. Liaison between [the rest home] and [Dr C]

There was no letter of referral from [Dr C], nor any evidence of a telephone referral by the doctor to the Rest Home. It was stated that '*all medical records were kept in the doctor's surgery prior to 13th August 2001'*. The information booklet advises prospective residents/families that 'the *resident or next of kin or agent … ensures that the original or copy of the medical records including all notes and drug administration chart are given to the registered nurse following each visit*' (to their own doctor).

There is no evidence prior to 13th August 2001 that any written documentation was received by [the rest home] from [Dr C] nor telephone instructions from [Dr C] to the

staff at [the rest home]. As [Mrs B] was visiting the doctor, had sustained injuries following falls and was experiencing pain I would suggest that a responsibility lay with the RN of the rest home to seek information from the doctor.

4. Management of deteriorating medical condition and mobility

The progress notes do not reflect the deterioration in [Mrs B's] condition. The second entry notes that [Mrs B] '*appears to be settling slowly … has developed troublesome cough*'. The sixth entry notes that '*there is no real change*'. The seventh entry notes that '*antibiotics given as ordered by [Dr C]*'. The following entry (? 13th August) notes that [Mrs B] was to '*increase frusemide and commence moduretic and change antibiotic*'. The tenth entry notes that '*condition slowly improving*', and the following entry on 17-08-20[01] notes that [Mrs B] is '*very slowly improving*'. However on the following day it was identified that [Mrs B's] '*condition deteriorating*'.

There is one note about [Mrs B's] fall, with no follow-up, no documentation of pain assessment and follow-up.

There is no record of management of urinary incontinence, apart from the progress notes. There is no record of skin excoriation. The only reference to skin is on admission that '*skin satis*' and '*some dry patches on lower legs*'.

As skin excoriation had not been identified, there was obviously no treatment initiated to alleviate [Mrs B's] pain and discomfort. [Mrs B] was a resident who had multiple medical problems. It was noted by [Mr G] that '*she was a very sick lady on admission with co-morbidity ...*' There is no evidence of other progress being effectively monitored, of the Registered Nurse contacting the doctor and requesting him to visit. [Mr G] states that '*it is inappropriate to put blame on [the rest home] … the family by their choice was responsible for visit to surgery and medication supply as charted by doctor*'. *(Letter to [HDC] 31.10.02 (pg 4).)*

[The rest home's] 'Code of Residents Rights' identifies that residents have the right to expect that a level of care consistent with their assessed needs is provided. There was no evidence of Visiting Practitioners guidelines. It is of concern that [Mrs B] was admitted on 3-08-20[01] and was not seen in the Rest Home until 13-[08-01]. [Mrs B] was seen at the doctor's surgery, but no information regarding those visits was given to the Rest Home staff. It does not appear that the Rest Home staff sought information from the doctor, despite [Mrs B] being a '*sick lady on admission*'. It would seem that [Mrs B's] needs were neither assessed nor met.

5. Documentation and management of falls

The lack of documentation relating to [Mrs B's] falls is in direct contravention of the [the rest home's] Policy Qan 20.0 Incidents which identifies that '*all incidents and accidents are to be reported to the manager and or RN. It is the responsibility of the manager or RN to document the incidents and the treatment provided in the Incident Accident Register*'. [Mr G] states that '*minor incidents and accidents are fully investigated, but not reported in the incidents book … avoids recording any incidents that may not have occurred*'.

This would seem to imply that some reported incidents have not happened. Without investigation, how could this be determined?

[Mrs B] was known to use a walking stick and had a history of recurrent falls ([Mr I] pg 2). There were no side rails available. The Ministry of Health Investigation (pg 7) cites the Old People's Homes Regulations 1987 37(2)(a) on the provision of suitable equipment. [The rest home] has policy and procedures relating to Resident Falls. It does not appear that the procedures were adhered to nor the policy enacted.

In her letter 5-02-02 [Ms A] states that '*the rest home nurse never disclosed my mother's injuries to me. The rest home manager [Mr G] did not inform me of her falls.*' The Code of Health and Disability Services Consumers' Rights no 6 is the Right to be Fully Informed. The [the rest home] Code of Residents Rights no 4 states that the residents ha[ve] the right [to] '*expect that they receive adequate information … or some other person so entitled does so on their behalf*'. Both of the above rights were not adhered to.

Daughter [Ms A] identifies falls occurring 10.08[01] (not witnessed although helped up by caregiver, no incident form); 14/15.08.[01] [Mrs B] fallen (no incident form). 17.08.[01] falls from bed or chair – different stories on cause of fall. (No incident form [Ms A] reports that during the day (date not identified) '*she (mother) is sitting in a wheelchair in the kitchen while [Mr G] keeps an eye on her*'.

Note: I do not have the duty roster for the time frame which would identify the staff ratio. However, it would appear inappropriate to have a resident who had had several falls, presented with urinary incontinence and a sore perineal area, sitting in a wheelchair whilst a manager '*keeps an eye on her*'. In my opinion [Mrs B] should have been looked after by a caregiver, with oversight of the RN to ensure that any pressure on the sore area on her perineum was relieved.

It is acknowledged (as stated by [Mr G] pg 3) that '*due to brittle bone condition residents occasionally lose their balance and have a fall*'. With adequate assessment and planning it should be possible to reduce the risk of falls. Because of the lack of assessment and consequent plan of care for [Mrs B] it would appear that criteria 2.2.7 and 2.2.8 of the Health and Disability Standards relating to risk management were violated.

6. Management of incontinence

[The rest home] has developed policy and procedures to promote continence. Again, the lack of assessment and care plan would indicate that the policies and clear procedures were not followed. Qan.17.0 Elimination identifies incontinent aids, a clear flow chart on urinary infection and points to note with incontinent residents. There appears to be no recognition that there would be an increased flow of urine following the increase in diuretic medication. An appropriate toileting regime, assessed and documented, would have precluded the concomitant urinary burn. Qan 17.0 Elimination pg 10 identifies that '*the correct type and size of incontinent product is essential*'. No report of incontinence or the need for an incontinence product was noted in the progress

notes. It is not until between 14-17.08.[01] that [Mr G] recommended to [Mrs B's] son that incontinence products be purchased.

The urinary incontinence resulted in a urinary burn, which is not documented. It was stated by [Dr C] that on 17-08-[01] he '*thoroughly examined her but did not remove her nappy, so did not see any signs of ammonia dermatitis from urine contact that was reported the next day from [the hospital]*' ([Dr C's] letter to HDC pg 2). Mr G appears to suggest that there is no knowledge of the urine burn, stating that '*we have no knowledge of what could have happened to [Mrs B] following her transfer from resthome to the hospital and the time elapsed before the medical team saw her*'. It is my opinion that [Mrs B] suffered pain from such ammonia dermatitis during the latter part her stay in the resthome. This is consistent with her daughter's account of [Mrs B's] '*burnt bottom, pain*' and her mother's description *of* '*agony, agony, agony*'. The lack of both proper care and pain relief also lack of documentation is of concern.

7. Responsibility for hospital admission:

[Mrs B] was obviously a sick woman. Upon admission to hospital she was found to have a distended abdomen. When catheterised her urinary output was 700mls. [Mrs B's] perineal buttocks were found to be inflamed '*to the point of bleeding – query secondary to urinary burns*'.

Bandages on lower legs
Difficulty swallowing
Clinical notes 19.08[01] [the hospital]

It would seem that [Mrs B] required hospital care. An admission to the Public Hospital would be the responsibility of the General Practitioner. Should a private hospital be the preferred choice, then the family would be responsible for choosing which one. A needs assessment would have to be done to ensure funding, even in the case of a private payer. This would take time. In the case of [Mrs B] it is my opinion that an admission to the public hospital was necessary and that it was the duty of the general practitioner to arrange the admission.

8. Other matters:

- Drug Administration

  Linctus was given for cough (progress notes pg 2). Who prescribed this? Where are the 'standing orders' and by whom are they authorised?
  Why did the nursing staff not request written medication information from the doctor in view of [Mrs B's] acknowledged co-morbidity?

- Total Quality Care Complaints Policy would appear intimidatory in that it is necessary for the complainant to request the form and return the completed form to the senior staff member. Being able to send in the form and request an interview, with support person, would seem more user friendly. This may be why there was no complaint to [the rest home] during [Mrs B's] stay (Letter to [HDC] 31.10.01).

- There is no evidence to support the allegation that a caregiver slapped [Mrs B]

- No pain assessment was carried out, therefore the effectiveness or otherwise of the medication was not evaluated.

- No mental health assessment was carried out, despite history of moderate dementia.

In my opinion the care given to [Mrs B] fell below the appropriate standard of care.

The Code of Health and Disability Services Consumers' Rights 4 and 6 have not been met by the [the rest home] in this instance.

Additional comment

The lack of documentation, which includes assessment, planning and implementation of the plan, progress notes and incident reporting, fall well below the standard expected by a Registered Nurse. Such standard of care may be considered negligent, '*which falls below the standard of care which would be reasonably expected of a registered nurse … judged against the standards of his or her reasonably competent brethren*' (within Professional Misconduct, s 2 Nurses Act 1977).

Principle Two of The Nursing Council of New Zealand (NCNZ) Code of Conduct for Nurses and Midwives states that '*the nurse or midwife acts ethically and maintains standards of practice*'. In particular 2.3 identifies that the nurse '*is accountable for practising safely within his/her scope of* practice'.

There is no evidence in the documentation presented of either accountability or safe practice by the registered nurses employed at [the rest home]."

Additional nursing advice
Ms Hughes provided the following additional nursing advice after reviewing interview transcripts with Mrs E, Mrs D and Mr G, and the original copies of Mrs B's progress notes:

"**Purpose:**
To respond to the following questions:
1. Do you revise any aspect of your advice in light of the enclosed information?
2. Please comment on the adequacy of [the rest home's] on-call arrangement.
3. Please comment on the appropriateness of the roles undertaken by [Mrs E], [Mr G] and [Mrs D]?
4. Are there any other matters relevant to the care of [Mrs B]?

Response:
1. There is nothing within the interview notes provided to me that would cause me to revise any aspect of the advice submitted to the Health and Disability Commissioner 02-05-02.

Interview with [Mrs D]:

- The roster supplied to me is not of the dates in question. If this is a generic roster then there is a difference between the times stated by [Mrs D] during her interview and those on the roster.

- [Mrs D] advised that the only occasion [Mrs B] complained of pain had nothing to do with urine burns. [Mrs B's] daughter advises that her mother complained of 'burnt bottom pain'. There is no documentation of this.

- The use of a sanitary pad for incontinence would indeed have the effect of keeping urine onto the skin surface. There is no evidence, other than 'been told by the caregivers' that this occurred. The documentation from [the hospital] that [Mrs B's] perineal buttocks were found to be inflamed to the point of bleeding – query secondary to urinary burns would suggest that the urinary burn occurred prior to admission to [the hospital].

- I do not have a copy of the Rest Home Contract with the Ministry, which includes service specifications for subsidised residents. I have included a copy of Service Specifications from my own contract as I believe that the Contract is generic. However, as [Mrs B] was not a subsidised resident I am unsure of its standing.

- [Mrs D's] comment that she would not change the care that [Mrs B] was given would cause me some concern, particularly in regard to risk management for [Mrs B].

Interview with [Mrs E]

- [Mrs E] is a Registered Nurse who made a clinical observation to [Mr G] that [Mrs B] was a very sick lady who should have been admitted to a private hospital ([Mr G's] letter to [HDC] 21-10-01). [Mrs E] claims she 'had nothing to do with care' and yet appears to be used for advice on clinical matters.

…

- Verbal information given by the family members to [Mr G] ought to have been documented so that those caring for [Mrs B] could plan care accordingly.

2. The on-call arrangement is appropriate to the facility. The staffing is within the limits of the Old People's Homes Regulations (enclosed). [Mrs D] advised that either she is 'on call' at any stage, and [Mrs E] is always available for advice.

3. [Mrs E] advised that she only had a financial interest in [the rest home] as an Owner/Director. However she called the Rest Home on a daily basis and would give advice. In my opinion it would have been appropriate for [Mrs E] to follow up her clinical judgment that [Mrs B] 'was a very sick lady who should have been admitted to hospital'. The roster received also demonstrates that [Mrs E] is 'on call if required' for seven days a week. [Mr G] is the Manager of the facility, I have seen no evidence of his being a caregiver, nor is he reported as having a professional health qualification. Staffing, according to the submitted roster, appears to be adequate. I am at a loss to understand why [Mrs B], who had had several falls, presented with urinary incontinence and had a sore perineum, should

be sitting in a wheelchair while the manager 'kept an eye on her'. I am also unable to understand why [Mr G] did not ensure that [Mrs D] received information given to him from [Mrs B's] relatives. It is also surprising that it was [Mr G] who advised [Mrs B's] family about the need for [Mrs B] to have incontinence products. Surely this responsibility would have been that of the registered nurse. It would appear that [Mr G] acted in a capacity outside that which would be expected of a manager and was inappropriate.

The Service Specifications do identify the responsibilities of a registered nurse for subsidised residents. I would contend that the same responsibilities should include all residents. I previously reported my concern regarding the lack of documentation which is the responsibility of the registered nurse. This fulfilment of this responsibility was not evidenced in the material supplied to me. [Mrs D], in my opinion, did not ensure that [Mrs B's] care was of the standard expected.

4. Other matters relevant to the care of [Mrs B]

- It has been stated by [Mrs E] 'that families have a problem letting go of loved ones'. This is understandable, and there is a time of denial and grief. It [is] for this very reason that the care given should be of a high standard based on assessed needs of the individual and their family.

- [The rest home] is to be congratulated for ensuring that its documentation system has been improved. It is to be hoped that will include all aspects of residents' [care], a comprehensive incident reporting system and a user friendly complaints system."

Responses to Provisional Opinion

Mr and Mrs E
Mr and Mrs E made the following points in response to my provisional opinion.

Licensee's relationship

"The working relationship of [Mrs E] and [Mr G] was not as it is mentioned in the report. At the time of the complaint [Mr G] was sole in charge of running of [the rest home] with help of [Mr and Mrs E] for advice, some help in purchase of goods and administration."

Assessment

"[Dr C] requested urgent assessment of [Mrs B] … The assessment was done … after some 14 days delay. In our opinion some of the blame should be directed towards assessment department for their failure to arrange assessment urgently and under catagorising the client for cost saving as the expense of the health of the clients. If [Mrs B] was catagorised appropriately she would have been admitted to more suitable facilities such as a private hospital."

Urine burns

"[Dr C's] visit on 17th August 2001 at 9.00pm did not record any urine burns. … As there is no such record one assumes that at that time there was not evidence of severe urine burns. …"

Bruising

"The hospital admitting staff's records and next morning nursing records did not record any bruising … as described in the autopsy report. It may be possible that these bruisings happened during the 4 days stay in hospital."

Admission to rest home

"[Ms A] admitted … paragraph 6 that she was not going to return any form because she was concerned about the rest home claiming full funding for the care, if [Mrs B] does not stay full 28 days. … In my opinion this is poor excuse for not returning the forms that supplied vital information for the care of [Mrs B]. [Ms A] could have returned all other forms and held onto the payment authorization form … It is also unfair to totally blame the manager for not collecting the information. [Ms A] also would not sign the visitor's book so the manager had no idea of [Mrs B's] visits and outings. It appears the manager of the home has to perform heroic and impossible tasks to obtain information from family and doctors where one of more parties is unwilling to cooperate."

Complaint procedure

"I do not agree with Ms Hughes' statement that because the forms have to be requested it is intimidating … However we take note of Ms Hughes' suggestion."

Care provided to Mrs B

"The report totally blames the management of [the rest home] … even though other factors and personnel involved in the process for caring for [Mrs B] contributed to this less than adequate care. … There should be a safeguard built into the HD[C] Code for the management of the home against the family of the residents and health professionals who are unwilling to cooperate and provide necessary information to [en]able [the] rest home to provide good care …

In this report [Mrs D] (RN) at [the rest home] was unfairly criticised for documentation errors. It should be noted that we have found her to be [a] very caring person with good knowledge of care for the elderly. …"

Action

"We accept your recommendations and acknowledge we were in breach of some the HDC Code [rights] listed in this report."

Mr G

Mr G made the following points in response to my provisional opinion:

Mrs D

"In defense of our most caring, hands-on empathetic, efficient RN, [Mrs D], we find the accusations and reasoning behind the decision to accuse her of various breaches of the Code rather harsh. [Mrs E] was the controlling Matron of the rest home at that time and

was responsible for the overall care of residents, as well as staff management and training. [Mrs D] did what she was told. …"

Mr G

"In defense of the manager, his job detail was as per instruction from the Matron at the time. … His communication with [Dr C] was more than adequate. His communication with the … family was almost on a daily basis, at which time he always gave the family member an account of [Mrs B's] progress … His advice to the family that [Mrs B] was in need of incontinence wear was timely …"

Mrs B's falls

"We find it difficult to comprehend the bruising established at time of autopsy and that this was due to a number of falls. … What happened to [Mrs B] during her 5 days in hospital?"

Review of rest home practice

"A Ministry of Health inspection following [Mrs B's] departure established that appropriate paperwork had been put in place and that medical records, admission documents, nursing assessments and care plans for short stay were now undertaken in the same way that long term residents are.

The rest home is working towards certification for October next year. Under the guidance of ARCH we are currently working our way through a recent Ministry of Health audit and matching actions on the floor with the requirements of the regulations. We have the ARCH Quality Audit Programme and all procedures and documentation will be in place when we request audit for certification in order to attain this."

Ms A

Ms A made several points in response to my provisional opinion. She acknowledged that Dr C had provided "excellent care" to her mother over the years and had made a "one off" mistake in respect to leaving her mother at the rest home and accepts that Dr C did not breach the Code.

In respect of the rest home's comments about her controlling her mother's medication and taking her mother out (to doctor's visits) without informing staff, Ms A stated that there was only one visit out to the doctor during her mother's stay. Mr G was not present at that time so a caregiver was informed. Ms A told Mr G of the visit when she returned her mother to the rest home. She could recall one occasion when she told a caregiver that she was taking her mother out, but the message was not passed on. In respect of the visitor's book, Ms A stated that there was no visitor's book to sign.

Ms A denied that she had "controlled her mother's medication". She stated that she worked a 40-hour week and therefore was not in a position to control her mother's medication. She gave her mother's medication, and the medication chart written by Dr C, to the rest home when her mother was admitted to their care.

Ms A is adamant that her mother had several falls at the rest home and that the rest home failed to record them.

Ms A clarified that on the day of Mrs B's admission to the hospital a caregiver removed the incontinence pants her mother was wearing and placed a pad into her mother's underwear. Mrs B used a bedpan at the hospital and her pad was not wet. Ms A maintains that the urine burns occurred while her mother was at the rest home.

Ms A denies that the option of an ambulance transfer was suggested to her on 18 August by Mrs E. Had it been, she would have accepted the option. Furthermore, she denies that Mr G gave her the option of sending her mother to hospital, or sending her to a hospice or keeping her in the rest home.

Ms A concluded:

> "It is ridiculous for [Mr G] to absolve himself from responsibility of the medical care needs, planning or active intervention. That role is the responsibility of the manager, registered nurses, caregivers and ultimately the licensee of any rest home."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

…

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

(5) Every consumer has the right cooperation among providers to ensure quality and continuity of services.

Opinion: No breach – Dr C

Management of Mrs B's care
During her 16-day admission Mrs B's condition deteriorated from being mobile with a walker to being unable to sit or mobilise unaided.

Dr C denied that he failed to recognise Mrs B's deteriorating condition. He advised that he thoroughly assessed Mrs B each time he saw her and documented his findings and instructions in the notes. Mrs B deteriorated between his visits of 13 and 17 August. He recorded her deterioration and reduced mobility, and advised that private hospital care was now more appropriate for her.

My general practitioner advisor, Dr Turnbull, confirmed that Dr C's management of Mrs B was "very adequate". Dr Turnbull commented that when Dr C saw Mrs B on 30 July her medical condition was relatively stable and her admission to the rest home for respite care was prompted by her social situation. Following Dr C's visit to Mrs B on 13 August he "carefully followed through his management plan". When Dr C saw Mrs B on 17 August he recognised that her condition had deteriorated further and initiated an urgent reassessment of her support needs level, to enable her transfer to a private hospital following the weekend.

I am satisfied that Dr C provided an appropriate standard of care to Mrs B. I note that when Dr C saw Mrs B on 13 August he thoroughly recorded his findings and instructions for daily weighs and weekly blood tests, and asked to be contacted if her weight fell below 44kg. Mrs B's condition deteriorated rapidly after this visit and, when advised of this by Ms A on 17 August, he visited after hours that evening.

In my opinion the treatment and monitoring plan that Dr C put in place following his visit of 13 August was appropriate. When he was advised of Mrs B's further deterioration on 17 August, he attended promptly. I note that Dr C responded to Mrs B's fear of falling out of bed and enquired of management whether bed rails were available.

In my opinion Dr C provided appropriate medical services to Mrs B while she was a resident at the rest home in August 2001. I have seen no reason to doubt Dr C's own assessment that he "attended [Mrs B] professionally for 5½ years with a high level of skill and commitment". Accordingly, Dr C did not breach the Code.

Liaison with the rest home

Dr C was told by Ms A that the family had arranged to admit Mrs B to the rest home, despite the fact that the rest home was not on the list of rest homes recommended to her family. Following Mrs B's admission to the rest home Dr C was not asked by the manager, Mr G, to provide his notes in respect of Mrs B. Consequently, it was not until Dr C's visit to the home on 13 August that the rest home had access to Mrs B's medical history and a plan of treatment. Mr G advised that caring for Mrs B was difficult because the family liaised with her doctor directly, but he acknowledged that Dr C tried to keep him included. Dr C discussed Mrs B's management with Mr G following his visits on 13 and 17 August.

My medical and nursing advisors were critical of the rest home's liaison with Dr C. I am satisfied that the onus to initiate contact with Dr C rested with the rest home (specifically with the registered nurse), not with Dr C. In my view, Dr C liaised appropriately with the rest home and did not breach the Code.

Admission to hospital

When Dr C saw Mrs B on 17 August he noted that her condition had deteriorated to the extent that she could no longer sit or mobilise unaided and was incontinent of urine. It was

approximately 9.00pm on a Friday evening when Dr C arrived at the home to assess Mrs B. In his experience, the hospital was unlikely to accept a patient under the acute medical service for nursing care only.

My general practitioner advisor confirmed that public hospitals did not like to admit patients late on a Friday "without a readily identifiable reversal of the problems". Dr C elected to arrange for an urgent transfer to a private hospital instead. My advisor commented that Dr C's management of Mrs B was "very appropriate at all times".

In my opinion Dr C recognised that Mrs B's condition was deteriorating and that she needed a higher level of care. However, prior to her transfer to a private hospital she needed to be reviewed by a geriatrician, which could not occur until the following Monday. In the meantime, Mrs B was to remain at the rest home. When told by Mrs B and her daughter that Mrs B was frightened of falling out of bed, Dr C discussed the possibility of bed rails with Mr G. Dr C had an appropriate management plan in place for Mrs B, which he conveyed to her daughter and the rest home. Although there were shortcomings in the care provided by the rest home, Dr C provided a reasonable standard of care in the circumstances. Accordingly, Dr C did not breach the Code.

Opinion: Breach – Mrs D

Assessment and care planning
During Mrs B's 16-day admission a nursing assessment and care plan was not completed. Both my advisors were critical of the lack of documentation relating to Mrs B's admission, nursing assessment and care plan. The Ministry of Health also identified that the lack of a nursing assessment and care plan was a concern and stated that there should be no distinction between short-stay and long-stay residents in this respect.

The admission policy in use at the time of Mrs B's admission states that a nursing assessment and care plan is to be developed within 24 hours of admission, utilising the short-term care plan format in the first instance with a more comprehensive care plan to be developed after one to two weeks' observation. The admission policy was for "new residents" and describes activities that would be common for settling all residents, whether staying short term or long term. The policy did not distinguish between short-stay and long-stay residents.

The manager of the rest home, Mr G, and Mrs D, advised me that at the time of Mrs B's admission the rest home did not carry out nursing assessments on residents admitted for respite care. However, I note that Mr G advised the Ministry of Health that the same policies, procedures and forms were followed for short-stay and long-stay residents. Furthermore, it was understood by the rest home that Mrs B's family hoped she would settle into the home for the longer term.

While Mrs D cannot be held responsible for the failure by the rest home to have a policy that required short-term residents and/or residents admitted for respite care to be assessed,

she is accountable as a registered nurse to maintain her professional standards. My nurse advisor stated:

> "The lack of documentation, which includes assessment, planning and implementation of the plan, progress notes and incident reporting, fall well below the standard expected by a Registered Nurse. Such standard of care may be considered negligent ..."

In my view, the lack of nursing assessment contributed to Mrs B's deteriorating condition. The lack of a documented care plan meant that the staff caring for Mrs B could not respond appropriately to her needs. I note that my nurse advisor said that "with adequate assessment and planning it should have been possible to reduce the risk of falls". This was endorsed by my general practitioner advisor, who stated that "a fall risk policy was not considered and certainly not documented".

The Ministry of Health audit noted: "A lack of documentation for the assessment and treatment and care of a resident can compromise safety and well being for that resident."

In my opinion, by failing to complete a nursing assessment and care plan, Mrs D fell significantly short of the standards expected of a registered nurse and breached Rights 4(1), 4(2) and 4(4) of the Code.

Liaison with Dr C

There were no medical notes pertaining to Mrs B available to the rest home until Dr C's visit of 13 August. Until then, Mrs B's medical file remained at Dr C's surgery. Mr G advised me that he did not request Mrs B's notes from Dr C. However, Mrs D understood that Mr G had requested them but that they were "a long time coming".

The form "What to do when admitting a new resident" (Appendix 1) states: "Notify the relevant surgery that the resident is admitted into the R/H and ask them if they can send the medical notes to the R/H." In my view, in order to plan Mrs B's care, Mrs D needed her medical notes. The responsibility lay with her in the first instance to ensure that Mrs B's medical records were requested, and to follow up with the doctor if the records were not forthcoming. She took neither of these actions.

Mr G recalled that following Mrs B's visit to Dr C's surgery on 11 August Mrs B's family handed him "a piece of paper" with some instructions written on it when they returned Mrs B to the rest home. No other medical information was forthcoming. My nurse advisor noted that it was the registered nurse's responsibility to follow up with the doctor following this visit, to obtain medical information. However, Mrs D failed to do so. My general practitioner advisor commented that the rest home's liaison with Dr C was inadequate. She noted that Dr C's visit on 13 August seemed to be prompted by Mrs B's visit to his surgery two days earlier and that the rest home "was distant to this process".

Between 13 and 17 August Mrs B's condition deteriorated significantly, yet the progress notes do not reflect this, and Mrs D did not advise Dr C. It was left to Mrs B's daughter to alert Dr C to her mother's deterioration on 17 August.

In my opinion, by failing to ensure the rest home had timely access to Mrs B's medical notes, not following up after Mrs B's visit to the doctor on 11 August, and not acting on the

signs of Mrs B's deteriorating condition by alerting her doctor, Mrs D did not ensure safe and adequate care. Accordingly, Mrs D breached Rights 4(1) and 4(5) of the Code.

Management of urinary incontinence
Mrs B suffered from urinary incontinence after her diuretic medication was increased. On 18 August the hospital noted that Mrs B was wearing an incontinence pad and the next morning her urine burns were described as "severe". The burns remained until her death several days later.

I have received conflicting information about when the urine burns occurred. There is no record in Mrs B's notes of having urine burns. Mrs B complained of having a sore bottom during the afternoon of 17 August. Mrs D advised me that she assumed the pain Mrs B complained of stemmed from her fractured coccyx. Dr C advised me that when he examined Mrs B on the evening of 17 August he pulled down her nappy and did not see any signs of urine burns. However, later that night Ms A saw that her mother's bottom was "red like sunburn".

Mr G submitted that it was possible that the burns developed while Mrs B was at the hospital and that "dermatitis" could develop in a relatively short period of time. Mrs D advised that incontinence pads were not used except for very mild incontinence, as the pad held the urine close to the skin (causing abrasion). Mr G stated that when the family admitted Mrs B into hospital they requested a pad for their mother.

Ms A recalled that when she saw her mother in bed she noticed there was a pad in her underwear. Ms A's aunt, who was also present, could not recall what incontinence product Mrs B was wearing that morning but did recall a caregiver placing a pad in Mrs B's underwear as they were getting her ready for hospital admission.

I have been unable to establish at what point an incontinence pad was used on Mrs B, or when it was removed at the hospital. My nurse advisor noted that it was difficult to say how long it would have taken for Mrs B's perineum to become as burned as it was observed to be on 19 August. It is possible for burns to develop if either the pad or the patient is incorrectly positioned or moved, as skin can be torn away. My advisor concluded:

> "It is my opinion that [Mrs B] suffered from such ammonia dermatitis during the latter part of her stay in the rest home. This is consistent with her daughter's account of [Mrs B's] '*burnt bottom pain*' and her mother's description of '*agony, agony, agony*'."

On balance, I am inclined to accept the urine burns were present at least from the afternoon of 17 August. I am concerned by the measures that were in place to manage Mrs B's incontinence. Although Mr G claims that the rest home put in place two-hourly toileting for Mrs B and gave her incontinence pants from their stock, none of the preventative methods he describes are documented. There is no care plan and no description of the type of incontinence product used, despite the increase in Mrs B's frusemide.

Mr G also advised that residents sometimes limit their intake of fluid because they cannot get to the toilet in time, and that their urine consequently becomes concentrated. In my view, this is unacceptable. Given Mrs B's increase in diuretic medication and her frailty, her fluid intake and output should have been carefully monitored. There is no evidence that

it was. This was the responsibility of the registered nurse. In my opinion, therefore, Mrs D breached Rights 4(1) and 4(4) of the Code.

Falls

Mrs B complained of having several falls at the rest home. She told her daughter of falling in her room on 10 August. When Dr C reviewed Mrs B on 13 August he thought she had suffered a probable fractured coccyx as a result of this fall. He also noticed a skin tear on her lower left leg, which Mr G suggested may have happened when she crossed one leg over the other. Mr G also told Dr C that Mrs B had been "found" sitting by her bed. On 14 August Mrs B again complained to her daughter of having fallen and, on 15 August, Mr G told Mrs B's son that his mother had fallen from a chair. On 17 August Mrs D witnessed a fall and recorded this in Mrs B's notes. On 18 August Mrs B sustained a skin tear following an unwitnessed fall in her room.

The rest home denied that there were several falls and submitted that they may have occurred prior to her admission to the rest home. Mr G advised that he was aware of only one fall occurring on 17 August although he was also aware of Mrs B sustaining a skin tear on 18 August.

I note that there is no record of Mrs B having injuries present when she was admitted into the rest home, yet Mrs B's autopsy report states: "A number of bruises were present on the face and limbs which were consistent with having been received as a result of a number of falls." I am satisfied that Mrs B did indeed have a number of falls at the rest home.

Mr G advised me that staff were aware of Mrs B's history of falls but that it is difficult to predict falls in the frail elderly. He stated: "We have to allow freedom for the residents to move about, as that is their right." However, my nurse advisor commented that with adequate assessment and planning it should be possible to reduce the risk of falling.

Mr G advised that "minor incidents and accidents are fully investigated, but not reported in the Incident Book … This avoids recording any incidents that may not have occurred." My nurse advisor was critical of this practice. She commented:

> "This would seem to imply that some reported incidents have not happened. Without investigation, how would this be determined?"

My general practitioner advisor commented that all but the "most minor of falls" should be documented and the family told of them. Mrs B sustained injuries from her falls (a fractured coccyx, skin tears, bruising) yet only one fall was recorded on an incident form and one in the progress notes. On neither occasion was a pain assessment undertaken, nor (in the case of the unwitnessed falls) was a description of how the fall happened sought from Mrs B. Although Mr G reportedly asked Mrs D to assess Mrs B following the unwitnessed fall on 9/10 August, Mrs D failed to record any observations. All the falls should have been documented to enable a complete picture of Mrs B's fall risk, so that preventative measures could be put in place.

My general practitioner advisor commented that wedging a pillow under a mattress is "common practice" and "adequate under appropriate circumstances" for some residents at risk of falling. However, Mrs B's fall risk was never assessed in the first instance and

appropriate preventative measures were not taken. I note that some of her falls appear to have occurred when Mrs B was mobilising.

Assessing a resident's fall risk and putting preventative measures in place is the responsibility of the registered nurse. Mrs D failed to assess Mrs B's fall risk, failed to put preventative measures in place, and failed to follow the rest home's incident policy. In these circumstances Mrs D breached Rights 4(1) and 4(4) of the Code.

Documentation
Both my advisors were critical of the standard of documentation undertaken by the registered nurse, Mrs D, in the areas of assessment, planning, progress notes and incident reporting. Mr G claimed that the rest home maintained "full and accurate patient records" and that there had not been "any professional neglect" during Mrs B's admission. However, Mrs D advised that she has changed her practice since Mrs B's admission and now records more full progress notes as well as completing care plans for respite residents, in accordance with recent changes to the admission policy.

My nurse advisor commented that there was no evidence in the documentation of either accountability or safe practice by the registered nurses employed at the rest home. While Mrs B's confusion was recorded in her progress notes, her deteriorating medical condition, urinary incontinence, fall risk and falls were not. My general practitioner advisor stated: "I think the rest home's documentation at all stages was sloppy or inadequate."

I concur with my advisors. Mrs D's standard of documentation represents a serious departure from the standard of practice expected of a registered nurse. Accurate and complete documentation is an essential component of safe care. In my opinion, by not recording full and accurate notes relating to Mrs B's care and needs Mrs D breached Rights 4(1) and 4(2) of the Code.

Final comment
Mrs D stated that while she has amended her practice in respect of documenting more full progress notes, she would not otherwise alter the care given to Mrs B during her stay. In my view Mrs D's comment demonstrates a concerning lack of insight into the standard of her practice.

Opinion: Breach – Mrs E

Management of Mrs B's care
Mrs E denied that she had any involvement in the rest home beyond a financial interest as an owner and co-director. However, Mrs E is a registered nurse with a current practising certificate. The rest home documentation describes her as the matron and a registered nurse, "responsible for the overall care of residents". Mrs E "popped in" every day and answered any queries staff had relating to the care of residents, and provided registered nurse on-call support after hours.

Section 3(h) of the Health and Disability Commissioner Act 1994 ("the Act") defines a health care provider to include any registered health professional. As a registered nurse with a current practising certificate, Mrs E falls within this definition. However, even if Mrs E had not been a registered nurse, she would have fallen within the definition of a health care provider in section 3(k): "Any other person who provides, or holds himself or herself or itself out as providing, health services to the public or any section of the public, whether or not any charge is made for these services." Mrs E clearly held herself out as providing a health service every time she visited the rest home and gave advice to staff, including Mr G, about residents' health. Her role was not restricted to having a financial interest.

Mrs E recalled that she saw Mrs B "from a distance" soon after her admission. At that stage Mrs E thought that Mrs B was a frail looking lady and commented to Mr G that Mrs B should have been admitted to a private hospital rather than a rest home. Mrs E stated that she was aware of Mrs B's urinary incontinence, her history of having one fall and her confusion. Yet there is no evidence that she discussed her concerns with Mrs D and Dr C, or assisted with the planning of care. I agree with the comments of my advisor that it would have been appropriate for Mrs E to follow up her clinical judgement that Mrs B was a very "sick lady".

As the matron for the rest home, Mrs E had an obligation to ensure that Mrs B's care was adequate for her everyday needs and to initiate reassessment when appropriate. She did not do so. Although Mrs D reported to Mr G, Mrs E should have ensured that Mrs D's practice met the clinical standards expected of a registered nurse. I have found that Mrs D's practice was deficient in the areas of assessment, planning, and documentation. In my view, as senior nursing clinician, Mrs E should have been aware of the deficient aspects of Mrs D's practice and taken steps to rectify them. Accordingly, in my opinion Mrs E breached Right 4(1) of the Code.

Opinion: Breach – Mr G

Management of Mrs B's care
As discussed above, under the Act a health care provider includes a person "who provides, or holds himself … out as providing, health services to the public". While Mr G does not have any health professional qualifications, clinical staff report to him, he is the first point of contact for all on-call queries, and he took responsibility for liaising with Dr C in respect to Mrs B's test results, weight and ongoing care. Mr G also "minded" Mrs B when she was in a wheelchair in the kitchen where he was working. Accordingly, I am satisfied that Mr G held himself out to be a health care provider.

Mr G said that in his role as manager he was responsible for general staff management, the running of the home and admissions. Both my advisors were critical of the standard of registered nursing care provided to Mrs B. At no stage during Mrs B's 16-day admission was a nursing assessment undertaken, care plan documented or risk assessment performed. The incident policy was not followed and documentation of care was substandard. As Mrs D's manager, Mr G was responsible for ensuring she complied with rest home policies and,

in consultation with Mrs E, that her practice met professional standards. Most importantly, Mr G had overall responsibility as manager to ensure Mrs B received appropriate care in a safe environment. He did not do so. Mr G also failed to ensure the rest home's admission policy was appropriate for respite patients.

Mr G informed the Ministry of Health that the rest home experienced difficulty managing the care of Mrs B because her family controlled her medical management. Accordingly he "absolved himself" from that responsibility. However, his comments were not accepted by the Ministry of Health, which stated:

> "Despite any difficulties encountered, it would be expected that the manager ensures adequate assessments are undertaken at the time of a resident's admission and as required, and that appropriate documentation is maintained in a timely manner."

My general practitioner advisor was also critical of Mr G's comments. She stated: "This was his responsibility by regulation and he should have been communicating and working with the family much more positively to support [Mrs B's] needs." My nurse advisor also commented on Mr G's role, and stated that in her opinion he "acted in a capacity outside that which would be expected of a manager and was inappropriate", when he "kept an eye" on Mrs B and advised her family about her need for incontinence products.

I concur with my advisors. In my opinion, by not liaising more effectively with Mrs B's family and general practitioner, and in failing to ensure that nursing care of an appropriate standard was provided to Mrs B, Mr G breached Rights 4(1) and 4(5) of the Code.

Opinion: Breach – Mr and Mrs E, Licensees

Vicarious liability
Under section 72(1) of the Act employers are vicariously liable for any breaches of the Code by employees. Under section 72(5) of the Act it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing, or omitting to take, the action that breached the Code.

Mrs D was employed as registered nurse, and Mr G as manager, by Mr and Mrs E, the licensees of the rest home. There is no evidence that the licensees took appropriate steps to prevent the breaches of the Code by Mrs D and Mr G. Accordingly, Mr and Mrs E, as licensees/employers, are vicariously liable for the breaches of the Code by Mrs D and Mr G.

Mr and Mrs E submitted that there needs to be a provision for "the management of the home against the family of the residents and health professionals who are unwilling to cooperate and provide the necessary information to [en]able the rest home to provide good care of the residents". I draw their attention to clause 3 of the Code, which states:

"(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

(2) The onus is on the provider to prove that it took reasonable actions.

(3) For the purposes of this clause, 'the circumstances' means all the relevant constraints, including the consumer's clinical circumstances and the provider's resource constraints."

In all the circumstances, I am satisfied that staff management at the rest home, and Mr and Mrs E as licensees, have not established that they took reasonable actions in the circumstances in caring for Mrs B.

Other comment

Assault

My investigation has not substantiated Mrs B's allegation of being assaulted by a caregiver at the rest home.

Actions taken

Mrs D and Mr G, and Mr and Mrs E have provided apologies to Mrs B's family for their breaches of the Code.

Further actions

- A copy of this report, drawing attention to Mrs D's standard of documentation, will be sent to the Nursing Council of New Zealand.
- A copy of this report will also be forwarded to the Medical Council of New Zealand and the Ministry of Health Licensing Office.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1

Revision: A **DATE:- 14th AUGUST 1999**		**RESIDENT ADMISSION** **PAGE- 1 -OF 1** **QAN6.0DOC.DOC**

6.0 What to do when admitting a new resident

- Fill out the appropriate pages of section 7.1 (pages 1,2,3, 17,19,20) (RN only 4-9)
- Write in residents register
- Treatment book (list any dressing, eye drops, inhalers etc)
- Report book
- Breakfast list (what do they like for breakfast, how tea etc) Make kitchen aware of this new resident.
- Take necessary recordings

- Give following info:
  - Complaints form
  - Code of residents rights

- Make up a doctors notes file in office.
- Order necessary drugs and complete medication box.
- Fill out a drug sheet and signing list for medication.

- Introduce the resident to staff and other residents.
- Inform the resident about the bell system.
- Inform the resident about the meal times.

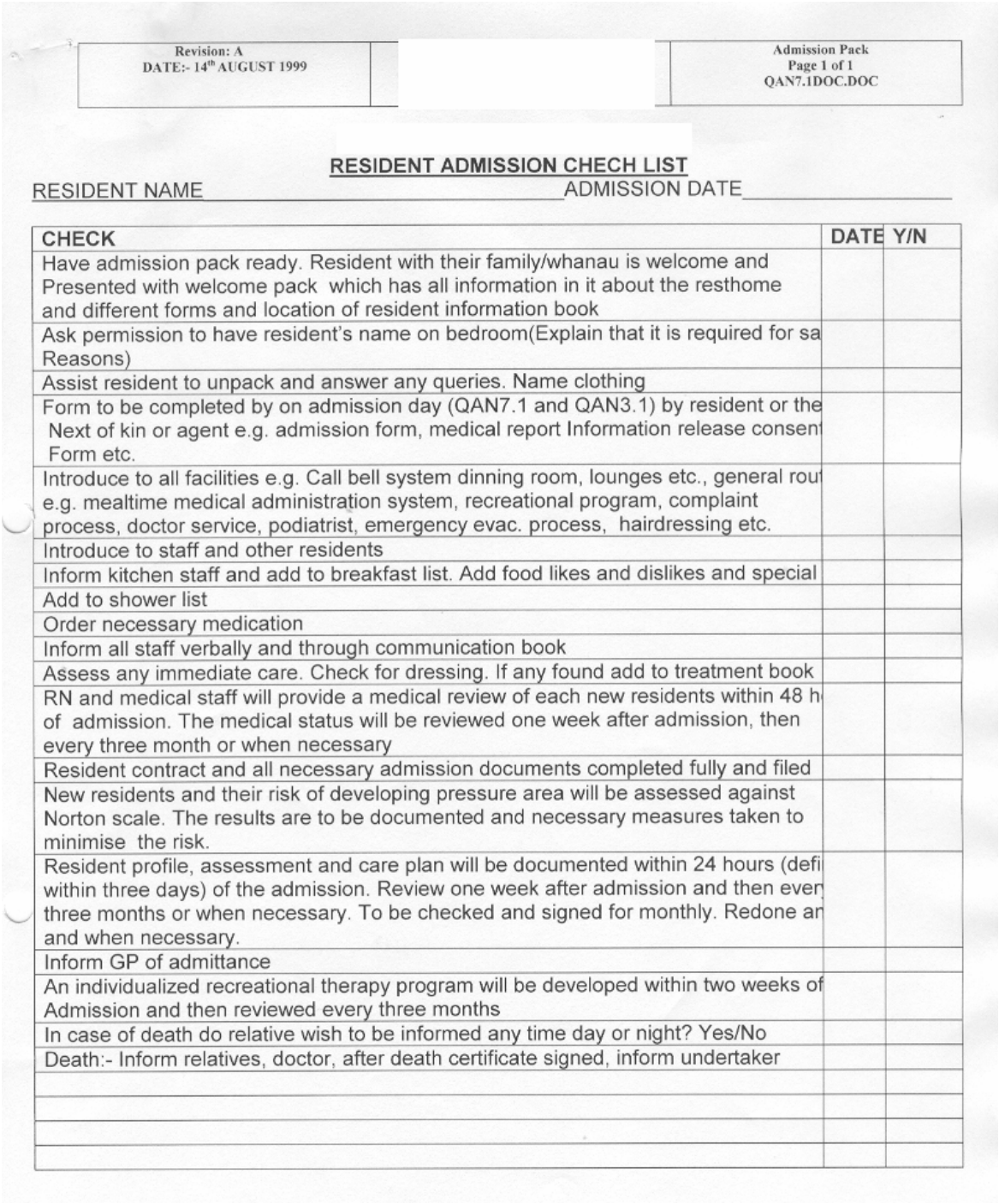
- If GP is not rest home Doctor are they changing over to him?
- Notify the relevant surgery that the resident is admitted into the R/H and ask them if they can send the medical notes to the R/H.

- Any hospital or specialist appointments coming up?

- If Nurse Manager is not in, complete:
  - -Residents care subsidy form
  - -Appointment of agent form

  and file in appropriate place

Appendix 2



Revision: A
DATE:- 14th AUGUST 1999

Admission Pack
Page 1 of 1
QAN7.1DOC.DOC

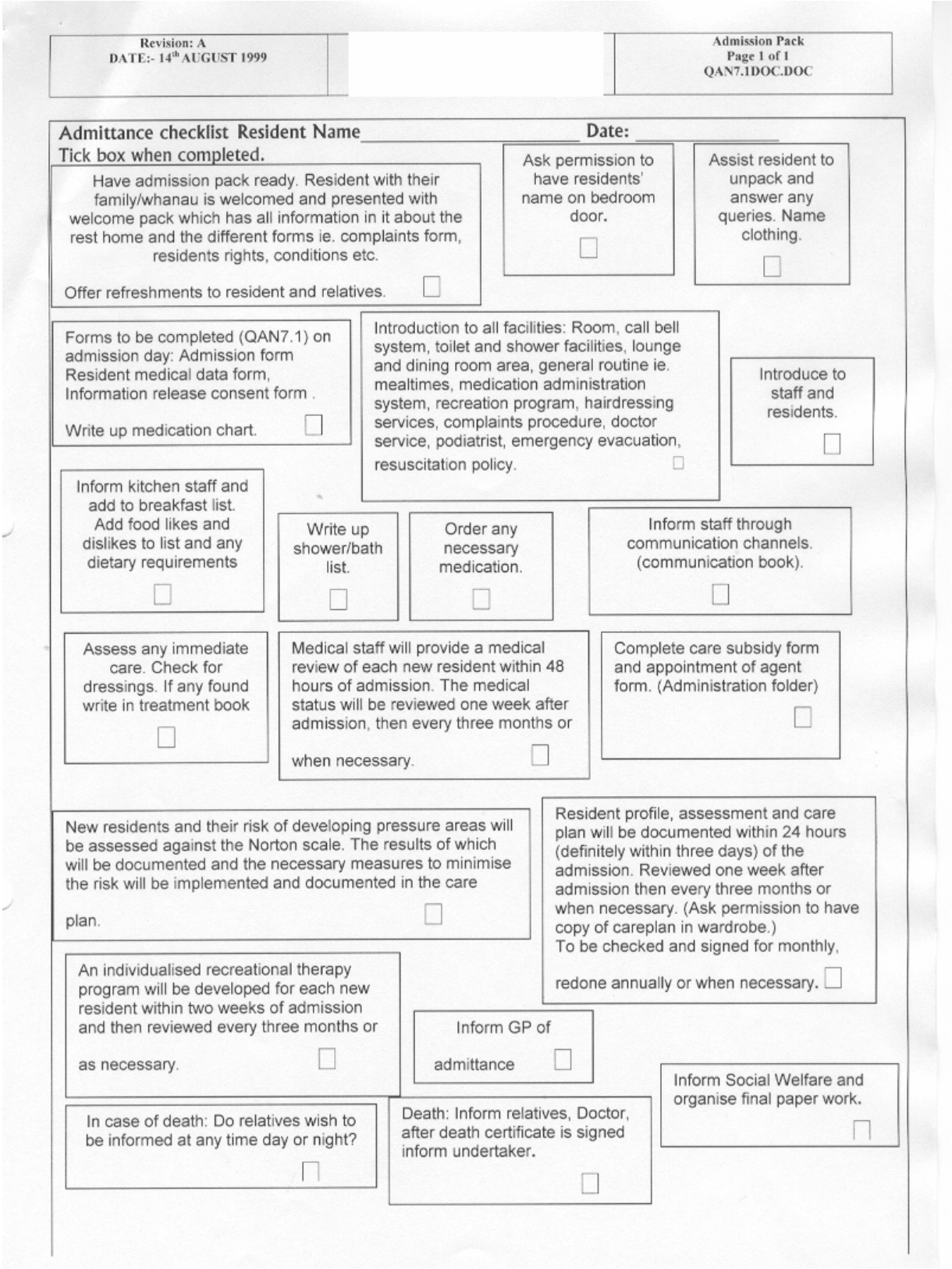
RESIDENT ADMISSION CHECH LIST

RESIDENT NAME _____ ADMISSION DATE _____

CHECK	DATE	Y/N
Have admission pack ready. Resident with their family/whanau is welcome and Presented with welcome pack which has all information in it about the resthome and different forms and location of resident information book		
Ask permission to have resident's name on bedroom(Explain that it is required for sa Reasons)		
Assist resident to unpack and answer any queries. Name clothing		
Form to be completed by on admission day (QAN7.1 and QAN3.1) by resident or the Next of kin or agent e.g. admission form, medical report Information release consent Form etc.		
Introduce to all facilities e.g. Call bell system dinning room, lounges etc., general rout e.g. mealtime medical administration system, recreational program, complaint process, doctor service, podiatrist, emergency evac. process, hairdressing etc.		
Introduce to staff and other residents		
Inform kitchen staff and add to breakfast list. Add food likes and dislikes and special		
Add to shower list		
Order necessary medication		
Inform all staff verbally and through communication book		
Assess any immediate care. Check for dressing. If any found add to treatment book		
RN and medical staff will provide a medical review of each new residents within 48 h of admission. The medical status will be reviewed one week after admission, then every three month or when necessary		
Resident contract and all necessary admission documents completed fully and filed		
New residents and their risk of developing pressure area will be assessed against Norton scale. The results are to be documented and necessary measures taken to minimise the risk.		
Resident profile, assessment and care plan will be documented within 24 hours (defi within three days) of the admission. Review one week after admission and then ever three months or when necessary. To be checked and signed for monthly. Redone ar and when necessary.		
Inform GP of admittance		
An individualized recreational therapy program will be developed within two weeks of Admission and then reviewed every three months		
In case of death do relative wish to be informed any time day or night? Yes/No		
Death:- Inform relatives, doctor, after death certificate signed, inform undertaker		

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 3



Revision: A
DATE:- 14th AUGUST 1999

Admission Pack
Page 1 of 1
QAN7.1DOC.DOC

Admittance checklist Resident Name_____ Date: _____
Tick box when completed.

Have admission pack ready. Resident with their family/whanau is welcomed and presented with welcome pack which has all information in it about the rest home and the different forms ie. complaints form, residents rights, conditions etc.

Offer refreshments to resident and relatives. ☐

Ask permission to have residents' name on bedroom door. ☐

Assist resident to unpack and answer any queries. Name clothing. ☐

Forms to be completed (QAN7.1) on admission day: Admission form Resident medical data form, Information release consent form .

Write up medication chart. ☐

Introduction to all facilities: Room, call bell system, toilet and shower facilities, lounge and dining room area, general routine ie. mealtimes, medication administration system, recreation program, hairdressing services, complaints procedure, doctor service, podiatrist, emergency evacuation, resuscitation policy. ☐

Introduce to staff and residents. ☐

Inform kitchen staff and add to breakfast list. Add food likes and dislikes to list and any dietary requirements ☐

Write up shower/bath list. ☐

Order any necessary medication. ☐

Inform staff through communication channels. (communication book). ☐

Assess any immediate care. Check for dressings. If any found write in treatment book ☐

Medical staff will provide a medical review of each new resident within 48 hours of admission. The medical status will be reviewed one week after admission, then every three months or

when necessary. ☐

Complete care subsidy form and appointment of agent form. (Administration folder) ☐

New residents and their risk of developing pressure areas will be assessed against the Norton scale. The results of which will be documented and the necessary measures to minimise the risk will be implemented and documented in the care

plan. ☐

Resident profile, assessment and care plan will be documented within 24 hours (definitely within three days) of the admission. Reviewed one week after admission then every three months or when necessary. (Ask permission to have copy of careplan in wardrobe.)
To be checked and signed for monthly,

redone annually or when necessary. ☐

An individualised recreational therapy program will be developed for each new resident within two weeks of admission and then reviewed every three months or

as necessary. ☐

Inform GP of

admittance ☐

Inform Social Welfare and organise final paper work. ☐

In case of death: Do relatives wish to be informed at any time day or night? ☐

Death: Inform relatives, Doctor, after death certificate is signed inform undertaker. ☐

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Appendix 4

Revision: A DATE:- 14th AUGUST 1999		Admission Pack Page 23 of 23 QAN7.1DOC.DOC

Name:-_____ Room # _____

COMPLETE ON ADMISSION AND EVERY 3 TO 4 MONTHS

Room # _____ NAME:-_____	Date:-	Date:
HEALTH ASSESSMENT Record specific problems and ability to perform tasks in following areas		
PARTICIPATION IN SOCIAL ACTIVITY Consider involvement in activities inside and outside the home		
EATING Consider condition of teeth/denture and mouth. Assistance required to eat and drink. Consider likes and dislikes, special diets. Ability to clean own teeth		
BREATHING Consider known health problems		
TOILETING Consider continence of urine and faeces during day/night and assistance required.		
BATHING/SHOWERING Consider condition of skin. Preferences. Assistance required		
DRESSING Consider ability to self dress completely and assistance required		
MOVING ABOUT Consider assistance required for mobility.		
HEARING AND SPEECH Consider level of hearing and hearing aid.		
EYE SIGHT: Consider vision and use of aids		
MENTAL HEALTH: Consider orientation to life. Are there problems forgetfulness, confusion and depression.		
SPECIAL TREATMENTS List medication and treatment for illness/health		
WEIGHT (Should be carried out monthly)		

SIGNATURE:_____

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Appendix 5

Revision: A DATE:- 14th AUGUST 1999		CARE PLANS PAGE- 1 -OF 3 QAN12.0DOC.DOC

12.0 CARE PLANS

Individualised Residents Care plans are essential to the provision of client centred care.
They allow for continuity of care, by-pass constant repetition of verbal instruction and facilitate communication between staff. Care plans are the holistic assessment and documentation of a resident's problem, the objectives and the staff intervention/care to solve/treat the problem and evaluation of the same. Resident, family, whanau, agent and GP involvement is encouraged.

POLICY:

To provide each resident with a suitable care plan which will cater for all personal needs and requirements. To plan care in an orderly manner.

OBJECTIVE:

Care Plans are written to assist staff to give the best quality care possible and ensure a cohesiveness of the care given. In plain language, easily understood by staff, the Care Plan states the problem, objective and care to be given, the same care by everybody, it gives the staff documentation at hand for them to refer to at all times. They do not have to remember all the care but need to know where to find it easily if they are unsure.
The objective is the residents expected outcome following specific intervention planned in response to the identified problems.
Objectives must be: resident centred identify the desired outcome

PROCEDURE:

A problem is an identified resident deficiency or potential deficiency. A nursing diagnosis is a concise statement of an actual or potential problem and its cause, which requires nursing intervention to be resolved.
On admission a nursing assessment is filled in together with resident/relative/agent.
A short term careplan is developed. Following 1-2 weeks of observation a more definite care plan is filled in after feedback from nursing-staff. All care plans are kept in CARE PLAN folder for each individually resident. The care plans are re-checked monthly and signed off or when necessary changed/updated using the care-plan monthly evaluation sheet (section 7).
Nursing staff is always expected to inform management if they feel that a care plan is not up to date or they feel the residents need of care has changed. At least once a year a care-plan in-service/meeting/survey is held to create a maximum of staff involvement

INTERVENTIONS:

Nursing interventions or care are specific directives planned in response to a resident problem with a specific goal or objective in mind. Nursing action should be clear concisely stated specific orders. Identify who is to do what and when.
Advise is asked, if appropriate and necessary, from outside disciplines, ie. Care Team, Stoma nurse, Dialysis nurse, GP, Physio, OT etc., to come to the best possible directive.

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Revision: A DATE:- 14th AUGUST 1999		CARE PLANS PAGE- 2 -OF 3 QAN12.0DOC.DOC

EVALUATION:

Is the measurement of success in meeting an objective. If necessary the nursing plan is modified.

DOCUMENT CONTROL:

On admission an assessment is done together with resident and relative and form filled in. Problem page (section 7.0) is filled in for specific problems. Section 7.0 (progress note) is updated daily. A monthly evaluation form is used for follow-ups. Fill out appropriate form from section 7 if conditions change, or when status quo.

SHORT TERM CARE PLANS
(QAN 12 Page 3)
These are stated in report book, message book and treatment book and transferred to progress notes. Intervention is on a day to day basis.
They are discontinued as problems are solved on a daily basis.

RESPONSIBILITY/AUTHORITY

The Nursing Manager or her designate is responsible for reviewing and updating care-plans.

Appendix 6

Revision: A DATE:- 14th AUGUST 1999		CARE PLANS PAGE- 3 -OF 3 QAN12.0DOC.DOC

SHORT TERM CAREPLAN

Name:_____Room No:_____ Doctor:_____ D.O.A

Current health status:_____

Activity of daily living	Resident Abilities and Limitations	Personal Preferences	Care and Support Needs
Hygiene and Dressing			
Mobility and Risk of falls			
Pressure area care			
Communication, Sight & Hearing			
Diet & Fluid requirements			
Social & Recreational needs			
Special needs and Instructions.			

Date Commenced:_____RN Signature:_____ Review date:_____

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Revision: A
DATE:- 14th AUGUST 1999

RESIDENT CARE PLANS
PAGE-2 -OF 23. QAN6.0DOC.DOC

NAME:- _____ NUSRE _____ ROOM # _____ DATE _____

PROBLEM	OBJECTIVE	IND	SUP	DEP	CARE	EVALUATION
Eating and Drinking					Special care _____ Food Prep. _____ Assistance _____ Beverage _____ _____ _____ _____	
Eliminating					____Hrly Toileting –Times ____ Requires reminding, Require Assist Comode _____Urinal _____ Incont Aid _____ _____ Catheter _____ Aparients _____	
Personal Cleaning And Dressing					Bath/Shower _____ Face /Hand _____ Teeth _____ Skin/Nails _____ Hair _____ Surgical Dresssing _____ Dressing _____ _____ _____ _____ _____	

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RESIDENT CARE PLANS
PAGE-2 -OF 23, QAN6.0DOC.DOC

Revision: A
DATE:- 14th AUGUST 1999

PROBLEM	OBJECTIVE	IND	SUP	DEP	CARE	EVALUATION
Moblising					Walking Stick Walker Frame Wheel Chair	
Inside					Requires Assistance Transferring	
Outside					Requires supervision/Assistance _____	
Wonderine					_____	
Communicating					_____	
Verbal					Word Board _____	
Hearing					Hearing Aid _____	
Seeing					Glasses _____	
Working and Playing					_____	
Self Motivation					Physio _____	
Active Participation					O.T. _____	
In home Function					Video _____	
					Library _____	
Maintaining safe environment					Church _____	
Smoking					_____	
Sleeping					Sedation _____	
					Aids _____	
Breathing					Nebulizer _____	
Controlling Pain						

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