Registered Nurse, Ms C

Registered Nurse, Ms D

Registered Nurse, Ms E

Registered Nurse, Ms F

Registered Nurse, Ms G

A Rest Home

A Rest Home Organisation

A Report by the

Health and Disability Commissioner

(Case 05HDC07285)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer (deceased)
Mrs B	Complainant/Consumer's daughter
A Rest Home	Provider
A Rest Home organisation	Provider
Ms C	Provider/Registered nurse
Ms D	Provider/Registered nurse
Ms E	Provider/Registered nurse
Ms F	Provider/Registered nurse
Ms G	Provider/Registered nurse
Ms H	Rest Home Manager
Ms I	Registered nurse
Ms J	Caregiver
Ms K	Caregiver
Ms L	Caregiver
Ms M	Caregiver
Ms N	Caregiver
Ms O	Caregiver
Ms P	Caregiver
Ms Q	Caregiver
Ms R	Chief Executive Officer (at the time of this incident), the Rest Home Organisation
Mr S	Chief Executive Officer (2006), the Rest Home Organisation

Complaint

On 17 May 2005 the Commissioner received a complaint from Mrs B about the services provided by a rest home. The following issues were identified for investigation:

- *The appropriateness of the care the rest home provided to Mrs A between 23 and 28 April.*
- *The appropriateness of the care registered nurse Ms C provided to Mrs A on 26 April.*
- *The appropriateness of the care registered nurse Ms D provided to Mrs A during the nights of 25/26 and 26/27 April.*
- *The appropriateness of the care registered nurse Ms E provided to Mrs A on 27 April.*

- *The appropriateness of the care registered nurse Ms F provided to Mrs A on 26 and 27 April.*

An investigation was commenced on 7 October 2005 and extended on 7 November 2005 as follows:

- *The appropriateness of the care registered nurse Ms G provided to Mrs A on 27 April.*

This investigation has taken over 15 months. There are two principal reasons for this. First, the length of time between the events occurring and the complaint being made impacted on HDC processes. Secondly, there was difficulty obtaining responses from some providers. Three of the registered nurses did not respond to our correspondence, and there were lengthy delays while attempts were made to locate the nurses and encourage them to respond.

Information reviewed

Information received from:

— Mrs B
— Ms H
— Mr S, Chief Executive Officer, the rest home organisation (2006)
— Ms C
— Ms D
— Ms G
— Ms F
— Ms E
— The Coroner
— New Zealand Police.

Independent expert nursing advice was obtained from Dr Stephen Neville.

The following responses to my provisional opinion were received:

— Ms C, dated 20 July 2006
— A lawyer (on behalf of Ms E, Ms F and Ms G) dated 3 August 2006
— Ms D, dated 3 August 2006
— Mr S (CEO, the rest home organisation), dated 7 September 2006.

Information gathered during investigation

Summary

In April, Mrs A, aged 94 years, was a patient in a rest home. On 18 April, she sustained a skin tear to her right arm. A week later, on 25 April, Mrs A vomited twice and was noted to have an elevated temperature of 38°C. She was given Pamol to control her temperature. The nursing orders were for Mrs A's temperature to be monitored four hourly. Over the following three days Mrs A's temperature was taken irregularly. The clinical records show that her temperature ranged between 36.2°C and 39°C. Her arm was redressed as required. On 27 April Mrs A's arm was noted to be red and swollen. At 5am on the morning of 28 April, caregiving staff reported to registered nurse Ms G that Mrs A's breathing pattern had changed. Ms G has consistently stated, when asked about these events, that she was unaware of this, and did not report a change in Mrs A's condition at handover. When registered nurse I saw Mrs A at 7.10am on 28 April she found her to be severely ill. Mrs A's right arm was grossly swollen, and black and purple in colour. Mrs A was transferred to a public hospital, where she was diagnosed with septicaemia. She died the following day.

The Rest Home

The rest home is administered by the rest home organisation. The total complex consists of rental flats, apartments, a hospital, and a rest home. References to the rest home in this report include the rest home organisation. Ms H, Manager for the rest home organisation, responded to questions asked of the rest home.

On 19 July 2001, the rest home organisation (the organisation) formulated Position Descriptions for registered nurses (see Appendix A). The document specified that the purpose of the registered nurse position was to "[s]upervise and provide clear direction to Care Staff placed under the Registered Nurse's direct control to enable them to achieve their goal of quality care". One of the key tasks and accountabilities for the registered nurse described in this document was to "[a]ttain and maintain the proper standards of care and well being for all residents". This document was revised on 1 January 2005.

In April of the year when these events occurred, the organisation had policies and procedures to guide staff in the care of residents. This information was made available to staff in Policy and Procedure Manuals, the Casual Staff Manual and the Health and Safety Manual. The following information was provided:

- Planning/Coordinating Resident Care
- Policy — Key Worker/Primary Nurse
- Guidelines — Clinical Records
- Notes for Wound Assessment (see Appendix B)

- Policy for Management of Wounds
- Procedure — Repair of Skin Tears
- Procedure — Taking a Temperature with a Digital Thermometer (see Appendix C)
- Acute Health Emergencies

In response to the provisional opinion, registered nurses Ms G, Ms F and Ms E stated that the policy regarding axilla temperature recording contained in the "Taking a Temperature" procedure document was not in place at the time of these events. They submitted that they had not seen the policy, and it had not been brought to their attention. It was noted that rest home Quality and Training Coordinator signed off all polices, but there was no sign-off on this policy.

Ms H advised that the "Taking a Temperature" policy has been in place for more than nine years. She said that this policy was contained in the basic care manual produced by Residential Care and referred to in a cross-reference in the rest home procedure manuals. The reason this policy had not been signed off by Quality and Training Coordinator was that it was a Residential Care policy. Quality and Training Coordinator signed off the rest home policies only. Ms H stated that all the staff have a responsibility to read the manuals provided and, if the registered nurses did not see the policy, it was because they did not look.

A Progress Visit and Certification Audit was conducted by a Quality Health New Zealand survey team on 29 and 30 October 2003. The surveyors concluded their report as follows:

> "Due to the number of changes within the nursing team, professional supervision has not been extended to this group. The Registered Nurses consistently reported a high level of support and supervision from their manager. … There are plans for access to a Professional supervisor to be extended. …
>
> There is evidence of a strong and continuing focus on quality improvement both at the governance and facility level. The management team and quality council provide strong leadership for the ongoing development, implementation and evaluation of the annual quality plan and quality projects. …
>
> It is evident that [rest home] has demonstrated continuous quality improvement since the last survey [on 30 April to 2 May 2002] in response to the areas they have set as priorities. The input from staff and the quality of documentation has improved steadily."

At the time of these events, it was the usual practice for the duty registered nurse to complete a "Handover Checklist" at the end of each shift. The checklist comprised a list of the current residents with comment columns for the three shifts, "AM" (7am to 3pm), "PM" (3pm to 11pm) and "NIGHT" (11pm to 7am). The checklists were to be

left for the Principal Nurse to view at 7am each day. A brief record was made of any change in a resident's condition and, if there was no change, the column was ticked. The checklist was also to be used as a prompt when handing over to the next shift.

Ms H advised that the organisation did not have an agreement with any one nursing agency. The casual nursing staff supplied by nursing agencies were provided with an information folder containing reference material on non-standard practices, such as the procedures to be undertaken in the case of an alarm sounding. She said that Ms C from a nursing agency had worked at the rest home a number of times previously.

Chronology

Mrs A was admitted to the rest home from another long-term care facility on 28 September 2001. She had suffered a TIA (Transient Ischaemic Attack — a "mini-stroke") the previous year, which resulted in her being assessed as requiring continuing care. Mrs A was prone to urinary tract infections and dehydration.

From September 2001 until the time of these events, Mrs A's condition remained relatively stable.

Fractured pelvis
On 8 March Mrs A slipped off the shower chair when she was left unsupervised in the shower. She sustained a skin tear to her right leg. The incident was reported to the registered nurse, who examined Mrs A and dressed the wound to her leg. Mrs A did not appear, at that time, to have any other injury, and the caregiver was given instruction on safe showering of residents. Mrs A was not reviewed by her general practitioner.

On 12 March Mrs A reported pain in her left hip and was reluctant to weight bear. She was examined by the registered nurse on duty. Ms A's blood pressure and pulse were satisfactory, but she had a bruise across her pubic bone, and was experiencing pain when she moved her left leg.

Mrs A was transferred to a public hospital for assessment. An X-ray revealed that she had a stable fracture of her left pubic ramus (pubic bone at the front of the pelvis). The instructions from the hospital to the rest home staff were to provide Mrs A with pain relief as required, start gently mobilising her according to pain levels, and provide pressure area cares while on bed rest.

Mrs A recovered well from the injury.

April events
On 15 April Mrs A was seen by a visiting general practitioner for a routine monthly assessment. The general practitioner assessed Mrs A's well-being, ordered a physiotherapy assessment of her mobility needs, and determined that she was well enough to be given a flu vaccine. Mrs A was given the vaccine that day.

On 18 April Mrs A sustained a skin tear to her right upper arm. Registered nurse Ms G recorded the skin tear in Mrs A's clinical records. Ms G also noted that she had recorded the injury on an Accident/Incident form. However, the Accident/Incident form providing details of this injury has not been produced. Information provided later by the rest home stated that the skin tear was assumed to have been the result of Mrs A scratching the site of her flu vaccine.

In response to the provisional opinion, Ms G stated that she placed the incident form, which detailed the injury to Mrs A's arm, in a folder specifically set aside for filing incident reports. The reports were then available for Charge Nurse Ms I, the team leader, to review and follow up.

On 20 April Mrs A was found to have a bruise to her right ankle and, on 22 April, a skin tear to her right shin.

On the morning of 23 April the nursing notes record that Mrs A's urine was "offensive smelling" (for the second time that month) and a urine specimen was "to be obtained" — to be sent to the laboratory for testing. Caregiving staff were instructed that Mrs A was to remain on a fluid balance chart to monitor her intake/output, and they were to encourage her with extra fluids. (There is no record in the following clinical notes that a urine specimen was collected, or that the doctor was informed that Mrs A had offensive-smelling urine and possibly a urinary tract infection.)

That night an agency nurse noted that she had Steri-stripped the skin tear that had been reported as occurring to Mrs A's right arm on 18 April.

25 April
On 25 April Mrs A vomited at dinner time, and did not have her meal. The registered nurse on duty that day, Ms G, noted that Mrs A's temperature was elevated at 38.6°C, and gave her 20ml of Pamol. Caregiver Ms M noted that Mrs A took small amounts of fluid that afternoon, with encouragement.

Ms M, in her statement to the police on 20 May, stated:

> "On the 25th of April I came back to work after having four days off and the first I learned of the injury that [Mrs A] had, was when [Ms O] and I went to do her washing cares.
>
> I noticed that her right arm had a tight bandage on it. It was a crêpe bandage. I thought the bandage was quite tight. It didn't seem to be bothering her. This was the first time I had seen it as it was covered by clothing.
>
> I went to get the registered nurse to come and have a look at the bandage as I thought it was quite tight. I also wanted to know why she had the bandage. [Ms G] came in and had a look. She released the bandage and it looked better. It wasn't so tight. I didn't see the wound.

> From there we went back to the doctor's room. We looked through [Mrs A's] notes and looked for the Incident form. We did not find an Incident form, but in the notes we found where a nurse had written that she had cleaned and dressed the wound."

Ms D was the registered nurse for the night shift (11pm to 7am) on 25/26 April. Ms D stated that she was not told that Mrs A had a skin tear to her right arm. She was told that Mrs A had vomited during the day and had a temperature, but by evening was improving. Ms D recorded that Mrs A did not vomit during her shift. At 1.30am Ms D noted, when turning Mrs A, that she had a number of scratches with associated pustules, "a rash type mark" on her left thigh. Ms D noted that Mrs A's temperature was elevated at 2am, when it was recorded as 38°C, and at 5am, when it was 38.6°C.

Caregiver Ms P worked with Ms D that night. Ms P said that she had no concerns about Mrs A during the shift.

26 April

The registered nurse for the morning shift (7am to 3pm) for 26 April was Ms F. Ms F informed the police on 8 July that she could not recall being told anything particular about Mrs A that morning, but the night shift handover must have included information about Mrs A because she instructed the caregivers to keep Mrs A in bed that day. Ms F stated:

> "I don't recall the time, but one of the caregivers spoke to me about [Mrs A's] right arm which was bandaged. The caregiver told me that [Mrs A] had pain in her right arm, so I went and saw [Mrs A] and I removed her dressing and bandage.
>
> When I looked at her right arm there was a round abrasion just above the elbow. It was the size of a 10 cent coin. There were two long steri-strips over the abrasion, which were covering it. The elbow area was a bit swollen. It was a bit red in colour.
>
> The bandage I removed from [Mrs A's] arm had no discharge on it and was clean and dry. My concern was that the bandage might have been too tight on her arm. …
>
> I knew this bandage must have been on [Mrs A's] arm for at least three days after reading the notes, which referred to the skin tear on the 23rd April. When a skin tear is sustained, the dressing will normally stay on for between three to five days to allow the skin tear to repair. …
>
> I went to check if an Incident & Accident Report had been written on this skin tear and there was nothing. … I then went back to [Mrs A] and cleaned her wound. I irrigated the wound with saline and I put a plain dressing over it. At that stage when I cleaned [Mrs A's] wound I wasn't too concerned as I thought it was a normal skin tear. The wound was slightly red, but I didn't think it was infected. I also took [Mrs A's] temperature after I cleaned her wound."

Ms M confirmed that she asked Ms F to look at Mrs A's arm. Ms M recalled that the wound was not weeping or bleeding and did not appear to be infected when she saw it that day.

Ms F noted on the handover checklist that she had taken Mrs A's temperature twice during her duty, recording Mrs A's temperature as 36.8°C and 36.7°C.

Ms C was the afternoon (3pm to 11am) registered nurse for 26 April. At that time, she was employed by a nursing agency. Ms C informed the police on 11 June that the nursing agency supplied nursing staff to private hospitals when they needed nursing cover. Ms C confirmed that she had worked at the rest home on a number of occasions. Ms C informed the police on 11 June:

> "I received a handover for [Mrs A]. They said she had a skin tear on her arm and a possible urinary tract infection [UTI]. She was to have her temperature taken four times a day, and the assumption was that her temperature was high because of the UTI.
>
> There was no specific handover about the arm, because it had been sighted recently and there didn't appear to be any infection in it. However, I did have cause to look at her arm, just for my own satisfaction that everything was okay. The time would have been around 5pm when I took her temperature. Her temperature at this time was 36.6°C. As I had taken it under her arm, her actual temperature would have been 37.6°C.
>
> I observed her arm during my shift and there was no evidence of wound ooze and no sign of infection apparent around the arm. … The wound was red around the edges, which I thought was no more than is usual for a wound that is recovering. I had no concerns over [Mrs A] at that stage. … During the course of the shift, none of the caregivers came to me with any concerns about [Mrs A]."

On 14 October 2005 Ms C stated that she was unaware of "normal practice" at the rest home regarding the assessment of suspected urinary tract infection. She understood that the handover instruction to take Mrs A's temperature four hourly and to administer Pamol four hourly was the normal practice at the rest home for managing this condition.

Also caring for Mrs A during that afternoon were caregivers Ms N, Ms J and Ms L. Ms L informed the police on 3 June:

> "The first time I can recall being made aware of [Mrs A's] injury was during [the 26th April]. I was told that she had a skin tear to her arm and that was being kept elevated. … I cannot recall exactly how her arm was. I am sure it would have been dressed, but I can remember that it was elevated on top of a pillow. From my memory [Mrs A] appeared comfortable. I did not see the wound. …

> It wasn't long after they had their meals that I had checked on [Mrs A] again and I noticed that she had vomited. The vomit contained food and did not contain any blood. [Ms N] and I changed her out of her soiled clothing and washed her down.
>
> I cannot recall exactly when, but I can remember questioning the registered nurse about [Mrs A's] arm. I think I asked about it, as the arm was swollen. I remember the registered nurse mentioning something about cellulitis. I cannot recall the exact content of the conversation."

Ms N informed the police on 20 May that she had been concerned about Mrs A's arm on 26 April. She recalled that the arm was pink and swollen and that she asked the registered nurse to check Mrs A's arm.

When questioned by the police about whether she had talked to the caregivers about cellulitis, Ms C stated that she spoke in general terms. She said that she was "just guessing" and that Mrs A's temperature was "fine". Ms C thought Mrs A may have had the start of an infection but there was nothing apparent clinically that indicated she had cellulitis. She did not consider asking a doctor to review Mrs A because all the recordings were "within the normal to upper range". Ms C stated that vomited, elevated temperatures and smelly urine are all symptoms of a UTI.

On 14 October 2005, Ms C stated that she did not recall being informed that Mrs A had vomited after her evening meal. She did not observe Mrs A vomiting. Ms C also said, "At no time did I say that Mrs A had 'cellulitis'."

There were no progress notes for Mrs A for the afternoon of 26 April. Mrs A's fluid intake and output were recorded on a "Fluid Intake and Output Record".

A temperature, pulse, and blood pressure chart, provided to the police by the organisation, was annotated "Chart completed 5 May from assorted documentation". This chart noted that Mrs A's temperature during the afternoon of 26 April was 36.8°C and 36.7°C.

Ms D was the night shift registered nurse for 26/27 April. Ms D was assisted during the shift by caregivers Ms Q and Ms P. Ms D informed the police on 2 July:

> "I had been told that [Mrs A] had vomited during the day, but that her temperature was okay. I went and checked on [Mrs A] and noticed that she was asleep. … I checked [Mrs A's] temperature during the night. The first time was at 2am. Her temperature was 38.9 degrees, so I gave her 20mls of Pamol again to help reduce her temperature. [Ms D took Mrs A's temperature under her arm]. … I rechecked [Mrs A] at 5am and her temperature was 39 degrees. I again repeated the Pamol. In between turns, [Mrs A] slept well and did not complain of anything. …
>
> I might have been told about [Mrs A] having a skin tear, but I cannot definitely remember, as it is not unusual for the elderly to sustain skin tears, so it might not have registered with me. During night shifts, I do not change any dressings for the

> patients, unless one has fallen off for one reason or another, but as a general rule we do not change them.
>
> [Mrs A's] temperature could have been attributed to many things during the night, such as the room could have been warmer than during the day. I was not too overly concerned about her temperature, as during the day it appeared to be alright and, it is not unusual for there to be an increase in temperature during the night."

Ms D recorded in the progress notes: "Temp ↑ 38.9°C. Pamol 20mls given @ 2.30am. Large BO tonight. T @ 5am 39°C. Pamol repeated. All care maintained. Slept well between turns."

27 April

Ms E was the morning duty registered nurse on 27 April. Caregivers Ms N and Ms L were also on duty. Ms E informed the police on 10 July:

> "I was told at change over that [Mrs A] had been vomiting during the PM shift the previous day (the 26th April) and was chesty and had a fever during the night. She had been given Pamol. …
>
> I took [Mrs A's] temperature during the morning. Her temperature was 37.5 degrees Celsius. I took this temperature under her arm. I also gave her 20mls of Pamol to help reduce her temperature. She had last been given Pamol at 5am, so we have to wait at least four hours before giving her any more. …
>
> When I went to [Mrs A] the caregivers had already taken her bandage off and given her a wash down. The wound looked like it was starting to get infected (sloughy). The surrounding skin was oedematous, which means it was a wee bit swollen. This was also pink and warm. I think her arm was warm because she had a temperature of 37.5 degrees.
>
> I took a swab of the wound, using a sterile stick. This is placed into a plastic test tube with special medium. I took this to be sent to the lab to make sure this wasn't anything serious. The wound did not have any discharge or smell coming from it. It was about 3–5 centimetres long and superficial. …
>
> At the end of my shift, during change over, I told the next person just to keep an eye on [Mrs A] because of her temperature. I explained that I had changed her dressing, but it didn't look serious. Also that there was no vomiting.
>
> I did not call a doctor for [Mrs A] because I did not think it was bad enough and her temperature was coming down and she hadn't been vomiting on my shift."

The Progress Notes for the morning shift for 27 April stated: "Stable. Temp 37.5°C Pamol 20ml given at Midday Dsg [dressing] done on R arm + L arm. R arm Wound swab taken. Tolerating meals and fluids well. For QID [four times daily] temp."

The Progress Notes for the morning of 27 April have an additional note recorded for that shift, annotated "28/4 Add" noting that Mrs A's wound was "slightly sloughy. Adaptic, interpose gamgee [dressings] and a bandage applied. Surrounding skin slightly oedematous and warm and pink. Visited by daughter." This record was initialled only. On 17 November 2005 Ms H advised that the initialled signature was by Ms E.

At 3pm registered nurse Ms F and caregivers Ms M and Ms O commenced duty. When Ms F was interviewed by the police on 8 July, she stated:

> "When I started this shift, the outgoing nurse, [Ms E] said that a wound swab had been taken from [Mrs A's] arm and sent away that morning to the lab. … When I saw [Mrs A] she was in bed. I told the girls to keep her in bed that afternoon. …
>
> At about 7pm one of the caregivers, [Ms M] called me to go and see [Mrs A]. She told me that she went to see [Mrs A] and tried to rouse her and she was just staring into space.
>
> When I entered [Mrs A's] room, I tried to rouse her. … She was lying on her back and unresponsive. This unresponsiveness lasted for approximately five minutes. At this time I took her vitals, which include her temperature, her pulse and her blood pressure. I recorded her vitals in the Progress Notes. I have reviewed the Progress Notes and can confirm that I recorded her temperature as 36.4 degrees, pulse of 70 [beats per minute — (bpm)] and her blood pressure of 210/77 [this recording may have been a typographical error by the police as clinical records state 110/77]. All these vital recordings are very normal for a person of her age.
>
> At the end of this five minute period, [Mrs A] became alert again. From that episode, I told the caregivers that [Mrs A] had probably had a TIA, which is a transient ischaemic attack. It is like a temporary mild stroke which can last for several seconds or several hours.
>
> When [Mrs A] became alert again, the caregivers gave her her supper. [Mrs A] was alright after that. … Throughout this TIA [Mrs A's] right arm was still bandaged and it was resting on a pillow. I didn't notice any significant change to her arm that afternoon. I did not remove [Mrs A's] bandage that day and look at her arm."

Ms M was assigned the care of Mrs A that afternoon. Ms M confirmed that Mrs A had appeared to have a mild stroke that evening but recovered. She stated:

> "Not long before I went off duty, I noticed that the bandage on [Mrs A's] arm was oozing in one place. This was about where the pillow and her arm were sitting together. The ooze was liquidy. It did not have a colour.
>
> When I noticed this, I went and got [Ms F] and she changed the bandage again. I was not present when this was done, as I had other residents to attend to. …

> [Mrs A's] arm appeared to be swollen. It was warm and pinky coloured. I thought [Mrs A's] arm was in a bad way. I did not tell anyone about my concerns as I thought they would already know.
>
> I changed the pillow that [Mrs A's] arm was resting on, about three or four times as her arm was weeping onto the pillow. It was only a small amount, but I changed it nonetheless."

Ms O confirmed that Mrs A's arm was weeping fluid during the evening of 27 April and that Ms F checked the wound.

Ms F recorded:

> "Called by caregiver at 1900hrs to see [Mrs A]. She was not even responding for five minutes. When roused just staring into space. Pupils … very fixed. Vitals taken, temperature 36.4, pulse 70, blood pressure 110/77. Query trans ischaemic attack. Given 20 mls Pamol when fully awake after that. Pillows placed to elevate right arm. Monitor temperature four times a day as charted. Otherwise tolerating fluids as offered."

In response to the provisional opinion, Ms F stated that she was unaware that Mrs A's arm was oozing because the bandage was dry when she saw it. She had not been told that the pillows were changed three or four times during the duty. Ms F stated, "I did not write in regard to the wound, as I did not attend to it on my shift, as I was unaware of any change to it." She said she would have changed the dressing if she had been told about the oozing.

Ms G was the night duty registered nurse on 27/28 April. Ms G informed the police on 2 July:

> "On [the 27th April] I was meant to have a day off, but was contacted at home and asked to work as they had no one for the night shift. … I started work at 11.00pm. I was verbally told by the registered nurse before me, [Ms F], that [Mrs A] had a possible mild TIA (mini stroke). I was told that [Mrs A's] arm was being kept elevated with a pillow because there was a wound on her right arm. I was not told any further information about the wound.
>
> I did my first round and checked on [Mrs A] at approximately 11.30pm. … I rechecked [Mrs A] at 2am. I checked her temperature. … I had decided at the beginning of the night, because of the TIA, that I would check [Mrs A's] temperature every four hours. I was not told to check her every four hours, it was my decision to do this. … At the time of this check her temperature was 37°C. …
>
> At 2.00am when I checked her temperature I also gave [Mrs A] 20mls of Pamol. I gave her Pamol to help settle her as it is also pain relief. I thought this might help with her arm. At this time I also checked her blood pressure which was 99 over

71. I also checked her pulse which was 100 [bpm]. The pulse was slightly elevated, above average. The blood pressure was normal for an elderly person.

I checked the wound at this time. The wound had been weeping and the lower part of her arm was slightly oedematous. The arm was pink. The bandage was on her upper arm, just above her elbow, and her lower arm was pink and slightly swollen. The pillowcase was damp. The dampness came from her wound and was tinged (serous fluid). The fluid had a slight blood/slight pus tinge. It wasn't green. It was a thin discharge. I changed the pillowcase at this time.

At 3.00am I returned to [Mrs A] and decided that I would see to the other residents that required medication and temperatures at this time, and then returned to [Mrs A] to sort out her dressing. I removed the dressing. I could not see where the skin tear was exactly. I could see slight oozing from around the area of the tricep. The discharge was the same as it was previously. It was slightly oozing. The arm was slightly swollen and pink which made seeing the skin tear difficult. The arm was not hot to touch. The wound did not smell at all. I wiped down the wound area with saline. … I placed a larger dressing on the wound. …

At 5.45am I returned to [Mrs A's] room to take her obs [observations] and to take her temperature. I took her temperature in the same way I did previously [in her armpit] and it was 37°C. I again gave her 20ml of Pamol. I also checked her blood pressure which was 106 over 72. I checked her pulse which was 102 [bpm]. … The hand was still elevated and the wound had not leaked through the bandage."

Caregiver Ms K was working the night shift on 27/28 April with Ms G and caregiver Ms J. On 20 May Ms K informed the police that she and Ms J first attended Mrs A between 2.30am and 3.30am and found that discharge from Mrs A's arm had soaked into the pillow. Ms K stated:

"I went and got [Ms G] and told her what we had found. She came back to [Mrs A's] room with me. We took the bandage off and re-dressed it.

[Ms G] was present with [Ms J] and I when we took the bandage off. When the bandage came off all I saw was what appeared to be fluid under the skin from the right elbow down to and including the hand. I said, 'What's that?' Meaning the fluid, as I had not seen anything like that. Either [Ms J] or [Ms G] said, 'It's just fluids'.

I held the arm up while [Ms G] and [Ms J] dressed it. [Ms J] was cutting the cotton wool for the dressing. I couldn't see the wound from where I was. I could see her arm and hand though. I said to [Ms J] at that time that the arm was hot. I could feel from holding it that it was very hot. No comment was made to that. I could not smell anything unusual or putrid when we were changing the dressing. I said, 'Look at her hand.' It was purple in colour. I said this to [Ms G]. She did not reply. …

> Just before we did the 5am round I saw [Mrs A] was breathing differently. It was shallow and tight. She was having difficulty breathing. I reported this to [Ms G] and she said that was okay. [Ms G] went and had a look at [Mrs A] with me. I then went on my rounds, leaving [Ms G] with [Mrs A]. …
>
> I went into [Mrs A's] room at about 6.30am and saw that the wound had oozed onto the pillow. I went and told [Ms G] and we both changed the pillow."

Ms J informed the police on 22 May that she cut up the dressing to assist Ms G, who dressed Mrs A's arm, but did not stay in the room while the arm was being redressed. Ms J said that when Ms K told her that Mrs A's arm was swollen and hot, she advised her to inform Ms G. Ms J recalled overhearing, just before she finished her shift at 7am on 28 April, Ms K tell Ms G that Mrs A's breathing was "funny".

Ms G informed the police:

> "Handover for the morning nurse was done at 7.00am. The next registered nurse was [Ms I], who was the Charge Nurse. During the handover, I advised the staff what had happened during the night with [Mrs A] and about her wound. I was quite concerned about her general condition and because of her wound, as generally, we do not have to do dressing changes during the night.
>
> I took [Ms I] with me to [Mrs A's] room and I showed her another patient I had also been concerned about during the night. I also took her and showed her Mrs A. I again reiterated what had occurred through the night. I told [Ms I] I was concerned about [Mrs A]. We did not discuss calling a doctor. I thought from the handover I was giving, the first thing [Ms I] would do would be to call a doctor instead of me mentioning it. It is more usual for the doctor to be called during the day for something like a wound. It would be different if it was something like a heart attack."

Ms G recorded in the Progress Notes that the pillowcase under Mrs A's arm was changed at 2am and 3am and that her arm was oedematous. Mrs A's temperature, pulse and blood pressure recordings were noted at 2am and 5.45am.

On 3 February 2006 Ms G stated that the handover on that morning of 28 April was "just a simple handover". She recalled that there was nothing about Mrs A's condition to make her aware that she required regular monitoring. Ms G stated:

> "I did not know or was told about her breathing. If it comes to that I would have done something straightaway like ringing an ambulance."

28 April
In response to the provisional opinion, Ms G stated that she was accompanied by a caregiver, "[…]", when she took Ms I into Mrs A's room at the handover round. Ms G stated that she was not told about the change to Mrs A's breathing.

Ms H advised that "[…]"was a caregiver employed by the rest home Hospital to work the morning shift Monday to Friday. This caregiver retired in February 2005.

Ms I informed the police on 13 June that Ms G's statement about handover was incorrect, and reiterated this in response to the provisional opinion. Ms I stated that when she first saw Mrs A at 7.10am on 28 April, in response to the concerns of a colleague about Mrs A's condition, she was accompanied only by two caregivers. Ms I said that when she saw the condition of Mrs A's arm she was so shocked that she had to leave the room momentarily. Ms I described Mrs A's hand as twice the normal size, black and purple. Ms I stated:

> "[Mrs A] was semi-responsive, which means that she was very vague looking, her pupils were fixed and dilated, staring into space. When we talked to her there was minimal response. When I saw the condition of her hand, I knew she had septicaemia."

Ms I went to the Nurses' Station and called an ambulance. The ambulance arrived at the rest home at 7.30am and transported Mrs A to a public hospital.

The public hospital

Mrs A was seen by surgical registrar at the public hospital emergency department on 28 April. The surgical registrar recorded that Mrs A's right arm was necrotic, swollen and ulcerated. Her fingers were blue. Mrs A's arm was not ischaemic (lacking in blood supply) but she had a "gross infection with septicaemia". The surgical registrar noted:

> "In my opinion debridement [cutting away dead/diseased tissue] was not an option, only alternative amputation which she would not tolerate at present."

The surgical registrar discussed Mrs A's condition with her family and it was decided that she would be provided with comfort care only, and was not a candidate for resuscitation in the event of an acute life-threatening episode.

Mrs A died a short time later. The surgical registrar notified the Coroner of the circumstances leading to Mrs A's death.

Coroner

The pathologist performed a post-mortem examination on Mrs A on 5 May. As a result of his examination he concluded that the cause of Mrs A's death was bronchopneumonia, and that cellulitis of her right arm was an "antecedent cause".

The Coroner asked the New Zealand Police to conduct an investigation into the circumstances leading to Mrs A's death. The police file was referred to the Coroner for final determination as to the cause of the death of Mrs A.

On 13 October 2005 the Coroner wrote to Mrs B to confirm that he was aware that this matter had been referred to the Health and Disability Commissioner. The Coroner informed Mrs B:

> "When I receive a copy of the Commissioner's report on the inquiry being carried out by him, I will decide whether the matters required to be established by me have been adequately established in respect of your mother's death … I will then decide whether there is a need for me to sit at inquest. If I decide there is no need to do so, I will issue my Findings as to the cause of your mother's death in terms of the evidence before me."

Investigation by the rest home organisation
Between 29 April and 6 May, the organisation's Chief Executive Officer Ms R, Ms H and Ms I reviewed Mrs A's clinical records and conducted a number of interviews with the registered nursing staff involved in Mrs A's care.

Ms H summarised her investigation into the events leading to Mrs A's death as follows:

> "My assumption is that [Mrs A's] death was caused by an infection in the arm, which later caused septicaemia. If the septicaemia was caused by an infection in the arm, then the following would be my comments regarding what should be considered normal good practice.
>
> - *[25 April] PM*. The doctor should have been notified when there was vomiting and a raised temperature.
> - *[26 April] AM*. When the night staff had reported raised temperatures and vomiting, a doctor should have been notified.
> - *[27 April] AM*. When the temperature had been raised over the two previous nights, vomiting, a suspected urinary infection, a suspected chest infection, the wound looked infected and a swab taken, the arm was oedematous and the daughter's concerns, the doctor should have been notified.
> - *[27 April] PM*. Looking at the history over the past few days as well as a suspected TIA, the doctor should have been notified.
> - *[27 April] night shift*. The nurse should have been concerned when at 3am she changed the dressing because of leakage. (There appears to be a significant change in status of the wound between the periods of 3am until 7.30am.) My opinion of this shift would be that it would be reasonable to expect the nurse to be worried about the state of the arm and at least be questioning what was done about it by examining the notes and documentations and initiating action by calling the doctor or ambulance.
> - Over the period concerned there was poor documentation of the events in the chart. Items of note were added to the chart by a registered nurse after

the patient had been discharged. These items might have assisted the nurses on subsequent shifts.

Summary

There appears to be several areas where good nursing practice has not been followed:

- Not calling the doctor when the signs and symptoms warranted this action.
- Not reading the previous shift's reports.
- Poor documentation and, documentation added after the discharge of the patient.
- Not assessing the patient's condition in a way which would be expected of a registered nurse."

On 17 November 2005, the current organisation's chief executive officer, Mr S, stated that specific improvements had been made as a result of Mrs A's death. These are as follows:

"1. Notification of change of health status was reviewed to include what to do if a temperature is elevated for more that two consecutive readings and to reinforce notifying families and doctors when residents are unwell.

2. The wound policies were amended to reinforce commencing treatment of a wound that is displaying clinical signs of infection prior to wound swab results being received. [The rest home] continued to teach the ACE training programme to the majority of caregivers where the importance of reading documentation and reporting to registered nurses is emphasised.

3. [The rest home] manager discussed the investigation with all RNs involved and implemented a monitoring system to assist them to maintain standards and make improvements to their practice. Specific ongoing supervision was offered to each of them."

Additional improvements were outlined in the minutes of the Review of Quality Improvements meeting of November 2004 and the quality action plan summary of Quality Improvements 2002–2005.

On 17 November 2005, Ms H stated:

"Items of note were added to the Nursing Progress notes … after the patient had been discharged. At the time, Charge Nurse [Ms I] found [Mrs A] at 7.30am on [28 April] she checked the previous day's entries to the notes. The entry by RN [Ms E] on 27/4 AM did not, we believe, initially include the statement that a wound swab was taken. …

'R arm wound swab taken.

> *28/4 Add Wound — slight sloughy → Adaptic/ Interpose/Gamgee* [types of dressings] *and a bandage applied. Surrounding skin slightly oedematous and warm and pink. Visited by daughter.'*

The Charge Nurse believed that the entry was probably made on the night shift of the 28th, after the patient had been sent to hospital, and possibly at the time the public hospital RN notified the rest home that Mrs A had died.

[Ms E] was interviewed on 29th April by [Ms R and Ms I]. [Ms R] asked [Ms E] if she had added information to the notes and [Ms E] replied that she had put it in last night. She thought she had put the information in at the time, but had written it in another book, so she added it the next day. She had no further explanation.

…

Following our investigation we considered what further actions we should take. We considered reporting the event to the Nursing Council as we believed that the nurses involved had breached the Nurses' Code of Conduct. We were advised by the police to wait for the outcome of the Coroner which may direct more specific actions.

We regarded the death as a Sentinel Event and looked at anything we could think of that may have improved the outcome. We tried to include anything at all that we could improve the resident's care, whether it would have had an impact on this case or not."

Ms H also advised:

"At the time of the event we were reviewing staffing levels and were in the middle of union consultation to change the way the rosters worked and to divide the home into a north and south wing with a mixture of both rest home and hospital residents having their own dedicated teams of staff.

An additional charge nurse position was established and two RNs planned for an afternoon shift rather than the previous one RN. … This change came about after consultation with staff and suggestions from them. One of note was that the RNs felt unsupported on their own despite knowing that they could call [the manager] or charge nurse at any time. …

We identified some changes to policies and procedures that would make our expectations clearer and documented a policy saying that it was necessary to contact the doctor if a resident had an elevated temperature. We also reinforced our policy to notify families of illness."

On 10 July Ms E was interviewed by the police about her addition to the clinical records. She stated:

> "At a later time, I added some comments to the Progress Notes, describing the wound, from the daily sheet kept at reception, which I had described the wound on. I do not know where that sheet would now be.
>
> When I started work on the 28th April, I was informed that [Mrs A] had been taken to hospital.
>
> I was concerned that there was no record of the skin tear being recorded on a wound assessment form or that there was no short term care-plan nor was there any incident form for the skin tear. This makes it harder to assess any progress of the wound healing."

In response to the provisional opinion, Ms E stated that the reason she did not enter the comments about Mrs A's arm on 27 April was that she was too busy. She said that she was unable to give an explanation for her actions when she was interviewed by the rest home management about this matter, because she felt isolated and intimidated.

Independent advice to Commissioner

The following expert nursing advice was obtained from Dr Stephen Neville:

"Thank you for giving me the opportunity to review and give advice on the above case. The aim of the contents of this report to the Health and Disability Commissioner is to provide advice, as to whether in my professional opinion:

[The rest home], as well as registered nurses [Ms C, Ms D, Ms E, Ms F and Ms G] provided an appropriate standard of care to [Mrs A].

Complaint

- *The appropriateness of the care [the rest home] provided to [Mrs A] between 23 and 28 April.*
- *The appropriateness of the care registered nurse [Ms C] provided to [Mrs A] on 26 April.*
- *The appropriateness of the care registered nurse [Ms D] provided to [Mrs A] during the nights of 25/26 and 26/27 April.*
- *The appropriateness of the care registered nurse [Ms E] provided to [Mrs A] on 27 April.*
- *The appropriateness of the care registered nurse [Ms F] provided to [Mrs A] on 26 and 27 April.*
- *The appropriateness of the care registered nurse [Ms G] provided to [Mrs A] on 27 and 28 April.*

This report will begin with an overview of my professional qualifications and clinical experience, followed by a timeline outlining the events surrounding [Mrs A's] stay at [the rest home]. Finally, my professional opinion on the case will be provided. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, my own professional clinical experience of working with older adults, my work as an academic researcher in the area of older person's health and after reviewing the relevant literature related to providing a nursing service to older people.

Personal and professional profile

I am a registered nurse, who has a doctoral degree in nursing, is a Fellow of the College of Nurses Aotearoa (NZ) and has been nursing for 28 years. I am currently working as a lecturer in the School of Health Sciences, Massey University, Albany Campus, Auckland. I last worked in clinical practice as a registered nurse in an assessment, treatment and rehabilitation unit for people over the age of 65 years in 2001. My other clinical experiences include people with disabilities, acute care, operating theatre and health care of the older person. I am currently Chairperson of the College of Nurses Aotearoa (NZ) Inc. My research experience and publications are in older men's health and well-being, delirium in people over the age of 65yrs, nursing and older people, the social aspects of ageing and health assessment.

Background

[Mrs A] was admitted to [the rest home] at the end of 2001 and was assessed on admission to have several health related problems related to a fractured right neck of femur, congestive heart failure, cancer of the left breast, a cataract in her right eye and a fracture in the region of T11–>T12. On the 23 April, Mrs A, then aged 94 years, suffered a skin tear to her right arm. The resulting wound was cleaned and steri-strips applied.

On 25 April, [Mrs A] experienced a bout of vomiting x2 and her temperature was recorded as being outside of the normal range at 38 degrees Celsius. She was treated with Pamol. In the nursing care plan a recommendation that QID (four times per day) temperature monitoring was required.

Over the next three days the temperature recordings were noted to range between 36.2 degrees Celsius and 39 degrees Celsius. It should also be noted here that on 2 May when [the rest home] began to investigate [Mrs A's] death the temperature chart could not be located. [Mrs A] was given regular Pamol as a means to address her persistently high temperature. During this time the skin tear on her arm was redressed as required.

On 27 April, [Mrs A's] arm was noted to be swollen, red and discharging. During the night of the 27/28 April the dressing on her arm required frequent changes due to significant amounts of ooze. At this time a swab was taken from the discharge associated with the skin tear. At this stage [Mrs A] was not referred for medical assessment. The only other intervention was the dispensing of Pamol. At 0500hrs the non-registered care staff reported to the duty registered nurse, [Ms G] that there was an alteration in [Mrs A's] breathing pattern. No action was taken relating to this issue.

At 0710hrs on 28 April the duty Charge Nurse, [Ms I], found [Mrs A] in a semi-conscious state, with a swollen arm (estimated at twice normal size) that was a purple-blue colour. Charge Nurse [Ms I] called an ambulance to take [Mrs A] to [the public hospital] where she was diagnosed with septicaemia. The family after considering all of the treatment options presented to them by the medical staff determined that no aggressive treatment regime would be implemented. [Mrs A later died].

Professional advice

I have been asked to advise the Commissioner on whether, in my opinion:

1. Were [Ms C's] actions in relation to [Mrs A's] symptoms (vomiting, elevated temperature and odoriferous urine) on 26 April reasonable?
2. Did [Ms C's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficit?

3. Were [Ms D's] actions reasonable when [Mrs A's] temperature was recorded at 38.9 degrees Celsius?
4. Did [Ms D's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficit?
5. Should [Ms E] have followed up on the urine specimen ordered on 23 April in light of [Mrs A's] elevated temperature during the night of 26 April and her vomiting? What would be the expected action in this situation?
6. What action should [Ms E] have taken on 27 April when she observed that [Mrs A's] arm was oedematous and her temperature 37.5 at midday?
7. Did [Ms E's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficient?
8. Were the actions taken by [Ms F] on 27 April when caregivers reported to her that [Mrs A's] arm was swollen and discharging, reasonable? If not, please comment on what action she should have taken.
9. Did [Ms F's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficient?
10. What actions should [Ms G] have taken on 27 April when [Mrs A's] temperature had been elevated for three days, and her right arm was oedematous and copiously discharging?
11. What was the likely reason for [Mrs A's] temperature to have been recorded at 37 at 5.45pm on 28 April, given her previous high temperatures and her arm infection?
12. Would it be reasonable for [Ms G] to have recognised the seriousness of [Mrs A's] condition on her shift? If so, please comment on [Ms G's] management of [Mrs A].
13. What action should [Ms G] have taken when caregiver [Ms K] reported to her the change in [Mrs A's] breathing?
14. Did [Ms G's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficient?
15. Were there adequate systems in place at [the rest home] to guide staff in the appropriate care of [Mrs A]? If not, what else should have been in place?
16. Should there have been someone taking responsibility for overseeing [Mrs A's] care and monitoring her condition? If so, who should have had this responsibility at [the rest home] and how should this have been undertaken?
17. If the oversight of [Mrs A's] care between 23 and 28 April was deficient, in what way was it deficient?

Finally, as required, I will comment on any other aspects of the care that I deem necessary. The following professional advice is presented as per points 1 through to 17 identified above. I have commented at the end of each point the level of severity associated with each of the actions. These are documented as mild, moderate or severe.

Preamble

Aged care facilities, such as [the rest home], provide a health service for a frequently medically complex population group. As the older population ages so too does the incidence of ill health. As such, older people live with a greater number of co-morbidities, for example congestive heart failure, cataracts and cancer. Most of the care provided in aged care facilities is delivered by unregulated staff. It is the responsibility of the registered nurse to delegate and supervise appropriate care tasks to these workers. Unlike many other clinical settings, community rest homes and hospitals do not have physicians and other health professionals on site at all times. It is therefore crucial that registered nurses have the appropriate knowledge, education and skills to provide quality health services to older people who reside in these settings. Consequently, nurses influence the quality of care provided to long-term residents, such as [Mrs A] in a variety of ways. A review of the nursing literature (see Eliopoulos, 2005; NZNO, 2002) on working with older adults in long term care has identified the following sets of skills and responsibilities required of a registered nurse:

- Assess and develop an individualised care plan based on assessment data.
- Monitor the older person's health status.
- Utilise rehabilitative and restorative care techniques when possible.
- Evaluate and document the effectiveness and appropriateness of care.
- Identify changes in residents' conditions and take appropriate action.
- Communicate and coordinate care with the interdisciplinary team, incorporating the views of the family and individual.
- Protect and advocate for the rights of the older person.
- Promote a high quality of life for the older person.
- Ensure clinical competence to be able to practise nursing older adults in a long term care facility through undertaking relevant education.

It is these skills and responsibilities that I will use as a model to guide my critical appraisal of the following points.

1. Were [Ms C's] actions in relation to [Mrs A's] symptoms (vomiting, elevated temperature and odoriferous urine) on 26 April reasonable?

The only documented actions by [Ms C], as they pertained to [Mrs A], were extremely minimal and were related to assessing fluid intake, temperature status and that she had been vomiting. [Ms C] demonstrated that she was able to monitor [Mrs A's] health status; however she did not demonstrate that she implemented or put in place any intervention strategies. In other words, [Ms C] undertook a series of technological tasks but did not apply any degree of critical thinking skills to the situation. Critical thinking is integral to nursing practice and is an essential intellectual skill that all registered nurses must possess in order to make sound clinical judgements (Cody, 2002). If [Ms C] had of engaged some level of critical

analysis to [Mrs A's] physical symptoms (high temperature, vomiting and odoriferous urine) she would have realised that this client's health status was compromised and that she needed further investigations to determine the cause of her presenting symptomatology. These may have included obtaining a second opinion from a colleague, from a more senior nursing person and/or from [Mrs A's] general practitioner. In addition, [Ms C] should have had current knowledge of physiology and pathophysiology associated with being an older adult. For example, on page 74 [Ms C] states '… Her temperature at 5pm was 36.6 and at 10pm was 36.2 … These were within the normal range for an adult, normal range being between 36.5 and 37.5 for an adult'. [Mrs A] is not an adult, but is an older adult whose health status was compromised. Infection and fever responses in older adults may vary from those of adults and [Ms C] should have known that. McCance and Huether (2005) identify that older adults may not show a rise in temperature in response to infection. I consider this fundamental knowledge that all nurses working with older adults must know. I therefore rate [Ms C's] actions with moderate disapproval.

2. Did [Ms C's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficit?

Adequate documentation on page 012 (the RN handover checklist) over viewing the key issues associated with [Mrs A's] health status on 26 April was provided. This brief synopsis detailed that [Mrs A] was afebrile and had vomited, but it did not identify that she had odoriferous urine. However, when reviewing the clinical progress notes there is a paucity of any documented assessment findings related to [Mrs A's] condition. In particular, there was no mention of her vomiting, temperature recordings, skin integrity and the quality of urine. [Mrs A's] fluid intake and output was recorded on a chart, a total intake of 250mls for the afternoon shift and that she had passed urine on two occasions. In addition, [Ms C] had documented [Mrs A's] temperature as being afebrile twice during her shift. However, the purpose of progress notes is not only to document a person's health and well-being, but also serves to pull together what has been written in other places, for example fluid balance, wound assessment and TPR charts, to provide a clinical overview that can then be handed over to other health professionals involved in the person's care. This was not done. Finally, any form of patient documentation is classified as a legal document. As such '[R]ecords should be legible, written in ink, signed and dated by the author …' (Jamieson, 1999, p.64). The R/N Handover Checklist is a legal document although dated and legible was not signed. In the clinical records each of the entries were dated and legible but were initialled and subsequently it was difficult, if not impossible, to determine who the signatories were. In light of my findings I view the above actions with moderate disapproval.

3. Were [Ms D's] actions reasonable when [Mrs A's] temperature was recorded at 38.9 degrees Celsius?

The actions that, in my professional opinion I consider to be appropriate considering the patient's temperature was recorded at 38.9, included regularly taking and recording of [Mrs A's] temperature, as well as the administration of Pamol. Pamol is well recognised as an antipyretic. However, [Ms D] should have utilised her knowledge of working with older adults and realised that a fluctuating temperature, as well as a temperature that is still consistently high especially one of 38.9 is a serious and life threatening situation. [Ms D] should have undertaken a full assessment (see competency 4 of the NCNZ amended 2002 Competencies for Registered Nurses), utilised her critical thinking and clinical decision-making skills to have made the decision to immediately seek medical assistance. I therefore rate [Ms D's] actions with moderate disapproval.

4. Did [Ms D's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficient?

Firstly, the literature on nursing documentation clearly identifies that information provided in clinical records form the cornerstone of the clinical decision-making process and the subsequent formulation of professional nursing judgements (see Robinson, 2002; Thompson & Dowding, 2002). In point 2, I identified that [Ms D] did not undertake an appropriate assessment of [Mrs A] considering her temperature was 38.9. This means that the quality of the documentation provided was limited. However, what was documented adequately reflected [Ms D's] actions. As in point 2 above, the R/N Handover Checklist, although dated and legible, was not signed. In the clinical records, each of the entries were dated and legible, but once again were initialled and subsequently it was difficult to determine who the signatories were. All registered nurses when documenting their actions must ensure documentation occurs in all the appropriate places, for example TPR chart and wound assessment chart. I rate the actions associated with this point as moderate.

5. Should [Ms E] have followed up on the urine specimen ordered on 23 April in light of [Mrs A's] elevated temperature during the night of 26 April and her vomiting? What would be the expected action in this situation?

All of the registered nurses, including [Ms E], involved in the care of [Mrs A] should have followed up on the urine specimen ordered on 23th April. This was all the more salient due to the patient's presenting symptomatology. Infections commonly experienced by older people living in Rest Homes include pneumonia, urinary tract infections, infected pressure ulcers and cellulitis (Weinryb, 2000). As in point 3, [Ms E] should have utilised her clinical decision-making skills to not only ensure that the results of the urine specimen were present but also should have arranged for an urgent medical consultation. In my professional opinion I would have expected that some form of clinical action would have been undertaken. There is little evidence that much occurred in this case. I would have included the following actions: four hourly temperature, pulse, respiration and

blood pressure recordings, a comprehensive assessment including auscultation and percussion of the posterior chest, swabs from any wounds (this was completed by [Ms E]) and fluid balance recordings. The findings from these nursing assessments would have provided enough clinical evidence for the registered nurses to insist on an immediate medical consultation and a request for a full blood screen with possible early transfer to an acute care setting. I rate the actions associated with this point as moderate.

6. What action should [Ms E] have taken on 27 April when she observed that [Mrs A's] arm was oedematous and her temperature 37.5 at midday?

Firstly, clinical interventions should have commenced long before 27th April. As with any intervention, assessment underpins all clinical decisions (Milligan & Neville, 2003). [Ms E] should have immediately sought a medical opinion and insisted that [Mrs A] be transferred to an acute care facility. In light of the above points I rate this action, or should I point out inaction, as moderate.

7. Did [Ms E's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficient?

[Ms E's] documentation of [Mrs A's] condition reflected her actions as a registered nurse in Mrs A's progress notes. All registered nurses when documenting their actions must ensure documentation occurs in all the appropriate places, for example TPR chart and wound assessment chart. As with points 2 and 4 above, the R/N Handover Checklist although dated and legible was not signed. In the clinical records each of the entries were dated and legible, but once again were initialled and subsequently it was difficult to determine who the signatories were. I rate the actions associated with this point as mild.

8. Were the actions taken by [Ms F] on 27 April when caregivers reported to her that [Mrs A's] arm was swollen and discharging, reasonable? If not, please comment on what action she should have taken.

This is difficult to answer because I have not been able to find what the actions performed by [Ms F] were. However on pages 133 to 134, Caregiver [Ms M] states 'Not long before I went off duty, I noticed that the bandage on [Mrs A's] arm was oozing in one place. This was about where the pillow and her arm were sitting together. The ooze was liquidy. It did not have a colour. When I noticed this, I went and got [Ms F] and she changed the bandage again. I was not present when this was done, as I had other residents to attend to. This was done about an hour before I went off shift. [Mrs A's] arm appeared to be swollen. It was warm and pinky coloured. I thought that [Mrs A's] arm was in a bad way …'. There is an adequate guideline for the management of wounds at [the rest home] that [Ms F] should have followed. I therefore rate [Ms F's] actions/inactions as severe.

9. Did [Ms F's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficient?

There is no evidence dated the 27th April that suggests that [Ms F] checked the status of [Mrs A's] wound or even looked at it other than to state '… Pillows placed to elevate R) arm…' (p.024). Therefore the standard of the documentation provided was extremely poor. A full description of the wound should have been provided and included wound size, shape, present condition, site, stage of healing, exudate (quality and quantity), pain as well as any other defining features. In addition, a full description of the interventions should have been presented in the 'Wound progress and dressing record' as well as in the progress notes. I rate this issue as extremely severe, unprofessional and unsafe.

10. What actions should [Ms G] have taken on 27 April when [Mrs A's] temperature had been elevated for three days, and her right arm was oedematous and copiously discharging?

There would have been two options available to [Ms G]; undertaking a conservative approach or an aggressive approach to this clinical situation. The basis for these decisions would have been undertaking a thorough assessment and following a clinical decision-making process. Following the gathering of assessment data [Ms G] should have utilised her clinical judgement (based on sound evidence) to have organised and prioritised the problems (potential infection in arm and elevated temperature) as a means to determining which clinical pathway she would utilise (conservative versus aggressive) (see Seidel, Ball, Dains & Benedict, 2006). A conservative approach would have been to have carried the set of interventions as described by RN [Ms G] in her statement to the police and what was documented in [Mrs A's] clinical records. In addition and missing from [Ms G's] actions, was any insistence to the morning staff that immediate medical attention was needed. An aggressive approach to this situation would have been to seek urgent medical attention. In light of my above comments I rate the actions associated with this point as moderate.

11. What was the likely reason for [Mrs A's] temperature to have been recorded at 37 at 5.45pm on 28 April, given her previous high temperatures and her arm infection?

As identified earlier in this report, temperature in an older adult is not a reliable indication of infection. In addition, the equipment used for taking a temperature may either have been faulty, or incorrectly used. In my professional opinion I would have expected that any sudden change in body temperature should always be thoroughly investigated. This is supported by Eliopoulos (2005) who warns that temperature fluctuations in older people are potentially hazardous and immediate action is required. If I was a registered nurse in this situation where the patient's temperature suddenly changed from being high to within normal range, I would have checked the equipment, checked my technique. In addition, if

someone else was available I would have sought another opinion and used another form of taking the temperature, for example a mercury thermometer. In light of my above comments I rate the actions associated with this point as moderate.

12. Would it be reasonable for [Ms G] to have recognised the seriousness of [Mrs A's] condition on her shift? If so, please comment on [Ms G's] management of [Mrs A].

In my professional opinion [Ms G] should have recognised the seriousness of [Mrs A's] condition given her clinical history of raised and fluctuating temperature, potential urinary tract infection and the signs of infection present in the skin tear on her arm. [Ms G] provided a barely adequate nursing service to this patient. There was a distinct lack of assessment, critical thinking and clinical decision-making evident. In light of these findings, I rate [Ms G's] actions as moderately severe.

13. What action should [Ms G] have taken when caregiver [Ms K] reported to her the change in [Mrs A's] breathing?

[Ms G] should have immediately gone to see [Mrs A] to determine the seriousness of [Ms K's] report. When assessing breathing patterns it is usual practice for registered nurses to note rate, rhythm and depth, and then chart these findings in the person's clinical notes. This did not occur and I therefore I rate this issue as being serious.

14. Did [Ms G's] documentation of [Mrs A's] condition meet the accepted standard? If not, in what way was it deficient?

Only some aspects of [Mrs A's] condition were documented in the clinical notes. While [Ms G] documented temperature recordings, the interventions provided to address a high temperature, the fact that the patient's arm was oedematous, the wound dressing needed changing due to ooze, blood pressure recordings, pulse recordings and that [Mrs A] had been taking some oral fluids, there were other aspects of this patient's condition that was not presented in the clinical notes. For example, there was no mention of [Mrs A] having difficulty in breathing. In addition, the quality and quantity of wound ooze was missing, as well as a description of the intervention provided in relation to managing the wound. Finally, no statement was made about the seriousness of [Mrs A's] condition and that she needed to be seen by a doctor first thing in the morning. In light of my findings I rate these actions as moderate in terms of severity.

15. Were there adequate systems in place at [the rest home] to guide staff in the appropriate care of [Mrs A]? If not, what else should have been in place?

[The rest home] has numerous systems in place to guide staff in the appropriate care of [Mrs A] and indeed any other older adult. These systems include clinical policies and procedures, for example policy lifestyle plans, policy and procedure management of residents and visitors' property, infections, drugs, security/safety, policy on cardiopulmonary resuscitation/serious illness, keyworker/primary nurse policy, management of wounds, procedures for weight, blood pressure and TPR. [The rest home] addresses quality issues by having in place an organisational quality framework and quality action plan. It is my professional opinion that adequate systems were in place at the time of the incident. However, the mechanisms for monitoring these systems obviously were not. There appeared to be a lack of clinical leadership in the facility. [The rest home], and indeed all long term care facilities, should have expert clinicians to monitor and ensure the organisation's quality systems are implemented. In addition, expert clinicians would provide clinical mentoring and leadership to registered nurses who not only provide nursing care to older people but also oversee the work of caregivers. These expert clinicians should be educationally prepared and hold a minimum of a clinical masters degree focused on working with the older adult. Clearly [the rest home] has a staff education programme in place as a means to keeping staff current in clinical issues relating to older people. However, staff education is only one means of keeping staff current. Formal education should also be mandatory for some staff, particularly registered nurses, for example participation in clinically focused post graduate study. This means [the rest home], as well as all residential care settings, need to include in their quality plans the mechanisms for releasing staff to participate in formal education. For example, days off to attend block courses and some financial assistance to help with the costs associated with studying at a tertiary level. In light of my findings I rate this point as moderate in terms of its severity.

16. Should there have been someone taking responsibility for overseeing [Mrs A's] care and monitoring her condition? If so, who should have had this responsibility at [the rest home] and how should this be undertaken?

On page 314 [the rest home] identify that the registered nurse on each shift is designated as the Key Worker, or Primary Nurse, and have identified a list of responsibilities for that person to undertake. This meant that [Mrs A] had a variety of registered nurses, each identified as a being the Primary Nurse. I believe that a consistent registered nurse should have been assigned to [Mrs A], someone who would have seen her on a regular basis and would have had an in-depth knowledge of her care needs. The registered nurses on duty would then have implemented the care plan and kept the Primary Nurse informed of any changes to [Mrs A's] health status. This did not occur in the present situation. There are many nursing models available in the public arena that the senior nurses at [the rest home] could have accessed that would have suited their long term care facility. For example, Cohen (2004) and Powell (2000). A full reference for these can be found in the reference list towards the end of this report. In light of my findings, I rate this issue as being moderate in terms of its severity.

17. If the oversight of [Mrs A's] care between 23 and 28 April was deficient, in what way was it deficient?

There was a series of unfortunate oversights in terms of the care provided to [Mrs A] during the period of the 23rd to the 28th of April. These oversights resulted in an unfortunate negative trajectory of events that led to the death of [Mrs A]. It is my professional opinion that both the organisation, as well as the registered nurses working during the above period, are responsible. While [the rest home] had a quality plan in place there appeared little mechanisms present to see the plan materialise into action. Organisations such as [the rest home] need to ensure they have appropriately qualified staff to provide clinical leadership within the facility. Equally, every registered nurse is responsible for the nursing service they provide as well as the appropriate delegation of tasks to caregivers. All registered nurses are responsible for their own practice. They need to therefore ensure they are knowledgeable and skilled in all aspects of working with older adults. This is all the more salient given nurses provide 24 hour health care and consumers of Rest Home services rely on registered nurses to know when to seek medical assistance. In light of my findings I rate this issue as moderate in terms of its severity.

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Responses to provisional opinion

Ms D
In response to the provisional opinion, Ms D stated that she accepts and apologises for her mistake but that the underlying cause of her mistake was partly understaffing. Ms D provided a letter addressed to Mrs B, in which she apologised for what happened to Mrs A.

Ms C
Ms C provided details of the nursing and aged care training she has since undertaken.

Registered nurses Ms G/Ms F/Ms E
Ms G's, Ms F's and Ms E's lawyer responded to the provisional opinion on behalf of registered nurses Ms G, Ms F and Ms E. Their legal advisor stated her concern that registered nurse Ms I's involvement as charge nurse/team leader "appears to have been overlooked". Ms G, Ms F and Ms E are "very concerned that they have been found in breach of the Code for things which we believe were the responsibility of [Ms I]". Their legal advisor submitted that a lot of the information provided by the rest home to the Commissioner was as a result of the internal investigation conducted by the rest home. Mrs I was involved in the investigation, asking questions and making decisions. Their legal advisor stated, "We believe the conduct of that internal investigation was neither impartial nor objective because [Ms I] had her own responsibilities to [Mrs A] and may have been protecting herself."

Ms G, Ms F and Ms E, who are overseas-trained nurses, advised that they were frequently allocated shifts at the weekend, nights or afternoon, and were responsible for 50 or more residents in the hospital and rest home wings with no other registered nurses to assist them. Ms I "was in the habit" of asking caregivers to carry out registered nursing duties. The caregivers often did not tell the overseas-trained nurses what they were doing, but reported directly to Ms I.

Their lawyer submitted that in previous cases involving aged care facilities, the Commissioner has investigated the actions of the team leader (as in Case 01HDC11139), finding that the team leader should undertake critical analysis and give encouragement to staff to reflect on events, to learn and to develop systems to enhance performance.

Their lawyer stated:

> "We are concerned at the number of times you have preferred the evidence of other staff to that of the [overseas-trained] nurses. Where there is disputed evidence or conflicting accounts, the credibility of the witnesses becomes an issue that should be tested by interview questioning when preferring one witness's evidence over another's. The Commissioner's office did not interview any of [the registered nurses]. They say if you spoke with them you would see they are telling the truth."

In relation to the findings against Ms F, her lawyer referred to Dr Neville's advice that Ms F should have changed Mrs A's dressing on 27 April. She submitted, "[T]his is not good advice on what is reasonable care in the circumstances. It would not be usual to change a bandage that is dry on the afternoon shift when it was only changed on the night before (when a wound swab was taken)." Her lawyer also disagreed with Dr Neville's advice that when Ms F found Mrs A's temperature to be fluctuating she should have checked her equipment and technique. Ms F advised that she would have assessed the equipment if she had thought the reading did not match the clinical signs. Mrs A was not showing any signs of having a temperature.

The nurses' lawyer advised that if there had been a temperature chart then Mrs A's fluctuating temperature would have been more obvious to Ms G and disputes Dr Neville's advice that Ms G's peers would view her actions in relation to this matter with moderate disapproval. Ms G also disagrees with Dr Neville's advice that her conservative approach to managing Mrs A was inadequate. The lawyer stated that Mrs A's condition had been ongoing, and the staff on earlier shifts had had easier access to medical assistance, but had felt no need to seek that assistance. Ms G submitted that she did "all that was reasonable for that time of the night". She is adamant that she asked Ms I to contact a doctor about Mrs A, not because she thought there was an emergency, but because she thought the arm wound should be "routinely seen by the doctor as a GP". Ms G states that she was not told about the changes to Mrs A's breathing early in the morning of 28 April. She is adamant that she accompanied Ms I to see Mrs A during the handover round at 7am on 28 April and that a caregiver was with them on the round.

Their lawyer stated that Dr Neville advised that on 27 April Ms E should have followed up on the urine specimen obtained for laboratory analysis four days earlier. Ms E advised that she was busy that day, because she was the only registered nurse on duty and responsible for 50 residents and patients in the rest home and hospital. Ms E stated that it was Ms I's responsibility to follow up the urine test results during the

week. In relation to Ms E's documentation, Ms E's lawyer quoted from the Commissioner's decision in Case 98HDC13685 that "a nurse's obligation to document … must be tempered by the practical situation". She conceded that Ms E's documentation was "not timely" and agreed that documentation is part of good practice. Ms E's lawyer submitted that the employer should ensure that there is adequate time on a shift for nurses to be able to do the documentation, citing *A-G v Gilbert* [2002] 2 NZLR 342 as precedent. Ms E's lawyer stated that Ms E should not be found in breach of the Code regarding her documentation when she was too busy on her shift, and took the trouble to record the information she thought necessary in retrospect.

Ms F's, Ms G's and Ms E's lawyer requested that the breach findings be reconsidered. She stated:

> "[Ms F and Ms G and Ms E] are truly sorry about the death of [Mrs A] and they apologise if they have breached her Rights under the Code. They do wish that they could have prevented what happened to her but they really are adamant that they did not know certain facts that you have assumed they did know. They ask you to please reconsider or re-investigate this matter.

The rest home organisation
In response to the provisional opinion, Mr S, the rest home organisation's CEO, stated:

> "[The organisation] has reviewed the provisional report it has been provided with from the Health and Disability Commissioner.
>
> Our comments are … :
>
> 1. The Certification survey team results that are referred to are from the Quality Audit that took place in October, almost 6 months after the period that has been the centre of this investigation. We would challenge the appropriateness of drawing comment from this therefore.
>
> 2. Mr Neville poses the question … 'Were there adequate systems in place at [the rest home] to guide staff in the appropriate care of [Mrs A]?' His report concludes that, '… It is my professional opinion that adequate systems were in place …' Given the short time span over which this incident occurred, and the fact that it was over a statutory weekend, we would contend [the organisation] was dependent on the registered nurses complying with those systems and using their professional skills.
>
> 3. Mr Neville's view is that there should have been a consistent registered nurse who was assigned to [Mrs A]. This was [Ms F], and we enclose the front cover of [Mrs A's] patient file which identifies her as such.

> We do not believe the findings made by Mr Neville support a view that [the organisation] breached Right 4(2) of the Code of Health and Disability services Consumers' Rights."

Further expert advice
In a follow-up telephone conversation on 29 September 2006, Dr Neville was advised that in response to the provisional opinion, registered nurses Ms E, Ms F and Ms G stated that they were overworked and there was poor communication from the caregivers they worked with. Ms F stated that it was unreasonable for him to have advised that she should have removed the dressing and viewed Mrs A's wound.

Dr Neville stated that he does not accept the excuse that the nurses were overworked. He said that this patient should have been identified as being of concern, and it takes no time to assess a patient's status. Most importantly, there was no previous description of the wound. When there is no record of a wound in the notes, the correct procedure would be to take down the dressing to check the status of the wound, and describe the wound, for following staff. This is critical analysis, and was not applied in this case. Dr Neville reiterated that these nurses did not provide Mrs A with basic nursing care.

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.

Other Relevant Standards

The Nursing Council of New Zealand's "Competencies for registered nurse scope of practice", approved by the Nursing Council in February 2002 (and re-named in September 2004) state:

"**4.0 Management of Nursing Care**

The applicant manages nursing care in a manner that is responsive to the client's needs, and which is supported by nursing knowledge, research and reflective practice.

Generic Performance Criteria

The applicant:

2.1 Uses an appropriate nursing framework to assess and determine client health status and the outcomes of nursing intervention.

…

4.3 Obtains, documents and communicates relevant client information.

4.4 Assesses and provides individualised nursing care based on appropriate knowledge, research and reflective practice.

4.5 Uses professional judgement, including assessment skills, to assess the client's health status and to administer prescribed medication and/or consult with the prescribing practitioner and/or to refer client to other health professionals.

4.6 Prioritise nursing actions to ensure effective and safe nursing care.

…

4.11 Directs, monitors and evaluates the nursing care provided by nurse assistants/enrolled nurses.

…"

New Zealand Health & Disability Sector Standards (NZS 8134 :2001) published by the Ministry of Health states:

"**Part 2** **Organisational Management …**

Quality and Risk Management Systems …

Standard 2.2 *The organisation has an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles.*

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

…

2.2.1 Relevant standards are identified and implemented to meet current accepted good practice in the relevant service area or setting.

…

Standard 2.7 Consumers/kiritaki receive timely, appropriate and safe service from suitably qualified/skilled and/or experienced service providers.

…

C2.7.3 *This may be achieved by but not limited to:*

(a) Ensuring appropriately qualified/skilled service providers are available to provide the service where professional expertise is required;
(b) Ensuring service provision reflects an appropriate skill mix combining both knowledge and experience;
(c) Ensuring adequate and appropriate supervision/direction/support is provided where required;
(d) Ensuring suitably experienced service providers are available to provide the service.

…

Part 5: **Managing Service Delivery** …

Outcome 5 *Consumers/kiritaki receive services in a planned and co-ordinated manner that comply with legislation and meet the needs of consumers/kiritaki.*

…

Recording Systems

Standard 5.2 *Consumers/kiritaki records are accurate, reliable, authorised and comply with current legislative and/or regulatory requirements*."

Opinion

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

Introduction
Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) state that every consumer has the right to have services provided with care and skill, and in compliance with professional standards.

The Nursing Council of New Zealand's February 2002 "Competencies for registered nurse scope of practice" states that registered nurses should manage nursing care in a manner that is responsive to the patient's needs and that is supported by nursing knowledge, research and reflective practice. The nurse should also use her professional judgement to assess the patient's health status, and document and communicate relevant patient information.

Breach — Ms C

Standard of care
On 26 April, registered nurse Ms C worked the afternoon shift at the rest home. Ms C, who had worked at the hospital on a number of occasions, was an agency nurse supplied by a nursing agency. The registered nurse on each duty at the rest home was designated as the Key Worker or Primary Nurse. As such, Ms C had key tasks and accountabilities, which included providing effective leadership to care staff to ensure that appropriate care was provided to the residents. The rest home provided casual staff, such as Ms C, with an information folder relating to non-standard practice at the facility.

My independent nurse expert, Dr Stephen Neville, confirmed that most of the care provided in aged care facilities is provided by unregulated caregivers. It is the responsibility of the registered nurse to delegate and supervise appropriate care tasks to these caregivers. It is therefore crucial that the registered nurses have the appropriate knowledge, education and skills to provide quality health services to older people in residential care facilities.

Ms C was given a handover on the residents under her care by the morning shift registered nurse. Ms Nelson was told that Mrs A had a skin tear on her right upper arm, and a possible urinary tract infection. Mrs A's temperature had been noted to be elevated on the previous two shifts, and the instruction at handover was that Mrs A was to have her temperature taken four hourly, and to be given the analgesic Pamol every four hours. (Pamol provides pain relief and also reduces fever.)

Ms C observed Mrs A throughout the shift and took her temperature in the axilla (under her arm). Ms C stated that Mrs A's axilla temperature at 5pm was 36.6°C and at 10pm was 36.2°C, which she stated was "within the normal range for an adult". (Axilla temperature recordings are a point lower than temperatures taken orally.) Ms C noted that, although the edges of Mrs A's arm wound were red, she was not concerned about the wound. Although caregiver Ms L recalled that Mrs A vomited shortly after the evening meal, Ms C does not recall Mrs A vomiting during the shift.

Dr Neville noted that Ms C was unconcerned about Mrs A because her temperature was "within the normal range for an adult". He stated that Mrs A was not an "adult" in the normal sense, but was an older adult whose health status was compromised. Mrs A's physical symptoms on 26 April, of elevated temperature, vomiting and odoriferous urine, indicated that her health status was compromised and that she required further assessment. Ms C should have been aware that older adults vary in their responses to infection and fever. Unlike younger adults, they may not show a rise in temperature as a response to infection.

Dr Neville advised that although Ms C undertook a series of "technological tasks", such as when she assessed Mrs A's temperature, she did not apply any degree of critical thinking to the situation when she considered Mrs A's temperature to be within normal adult range. I accept Dr Neville's advice that this is fundamental knowledge that would be reasonably expected of a registered nurse working with older adults. Thus, in failing to consider further assessment of Mrs A, Ms C did not comply with professional standards.

Clinical records

There was no clinical record for Mrs A for the afternoon of 26 April, but there was a separate record of Mrs A's fluid intake and urinary output on a fluid balance chart completed by the caregivers. Ms C was the registered nurse on duty, responsible for determining the care. She made no written instruction for the information of the oncoming staff about the need to monitor Mrs A's temperature four hourly and to give her Pamol. Although Ms C reported that she took Mrs A's temperature at "around 5pm" she did not record this anywhere.

Dr Neville advised that the purpose of the progress notes is not only to document a patient's health and well-being. The notes also pull together other documentation relating to the patient, such as fluid balance and temperature charts, to provide a clinical overview. This clinical overview can assist other health professionals to

implement or review a patient's ongoing treatment and care. Ms C did not provide any such documented clinical overview of Mrs A's health on 26 April.

Performance Criteria 4.3 of the Nursing Council of New Zealand's "Competencies for registered nurse scope of practice" states that nurses must obtain, document and communicate relevant client information. Accordingly, in my opinion, by her lack of critical analysis of Mrs A's condition on 26 April, and her failure to appropriately document a clinical overview of Mrs A for the information of other staff, Ms C breached Right 4(2) of the Code.

Breach — Ms D

Standard of care

Registered nurse Ms D was employed by the rest home l and worked the night shift on 26/27 April. At shift handover Ms D was informed that Mrs A had vomited during the day but her temperature was satisfactory. Ms D checked Mrs A's temperature twice during the night and found that it was elevated at 38.9°C at 2am and 39°C at 5am. Ms D gave Mrs A Pamol on both occasions to help reduce her temperature. Ms D was not "overly concerned" about Mrs A's elevated temperature as it had been normal during the day. Ms D considered that it could have been caused by a variety of things, such as the room being overly warm. She does not recall being made aware of the skin tear on Mrs A's arm.

As previously mentioned, my nursing expert, Dr Neville, advised that it is the responsibility of the registered nurse in aged care facilities to have the appropriate knowledge, education and skills relating to the care of older adults. Dr Neville advised that Ms D should have used her knowledge of working with older adults and realised that a fluctuating temperature, as well as one that is still consistently high, can be a serious and life-threatening situation. Ms D should have undertaken a full assessment of Mrs A, and made a decision to seek medical assistance immediately. I accept Dr Neville's advice that, in relation to Ms D's response to Mrs A's condition on 27 April, her peers would view her actions with moderate disapproval.

In my opinion, by failing to undertake a full assessment of Mrs A's health status, Ms D breached Right 4(1) of the Code.

No breach — Ms D

Clinical record
Dr Neville stated that although Ms D did not make an appropriate assessment of Mrs A, she adequately documented the observations she did make. The entries were dated and legible. Ms D only initialled her entry, which meant that it was difficult to determine who had made the record. However, the initialling of records was common practice at the rest home at that time. In my opinion, Ms D's documentation relating to Mrs A on 26/27 April does not amount to a breach of the Code.

Breach — Ms E

Standard of care
Registered nurse Ms E worked the morning duty on 27 April. She was informed at shift changeover that Mrs A had vomited the previous evening, was chesty, and had had a fever during the night.

Ms E took Mrs A's temperature once during the shift, at 10am, when she found Mrs A's temperature to be elevated at 37.5°C. She did not check Mrs A's temperature again during the shift. Ms E dressed Mrs A's right arm and found the arm to be swollen, pink and warm. When Ms E handed over to the afternoon staff she informed them that she had taken a wound swab, and suggested that they monitor Mrs A's temperature every four hours.

On 27 April, Mrs A was showing signs of infection. The most common infections experienced by older people in residential care facilities are pneumonia, urinary tract infections, infected pressure sores and cellulitis. There had been a report that Mrs A's urine was odoriferous and that a urine specimen was required for laboratory analysis four days earlier. Dr Neville advised that all the registered nurses involved in Mrs A's care should have followed up on the urine specimen ordered on 23 April. Dr Neville stated that clinical interventions in relation to Mrs A's symptomatology should have been commenced well before 27 April. If appropriate nursing assessments had been undertaken, these would have provided sufficient clinical evidence to indicate that a full blood screen, an immediate medical consultation, and consideration of early transfer to an acute care facility were warranted. This was all the more important in light of Mrs A's condition at this time.

In response to the provisional opinion, Ms E stated that she was busy on 27 April, and believed that it was the responsibility of the team leader, Ms I, to follow up on the urine test results during the week. However, I accept Dr Neville's advice that Ms E should have ensured that the results of the urine specimen were present and that this follow-up was "all the more salient due to the patient's presenting symptomology". The fact that the other nurses had not followed up the results does not mean that Ms E

did not have that responsibility. In light of Mrs A's condition that day, Ms E should have ensured that the urine specimen had been sent to the laboratory, and that the results of the urine specimen were known. She was sufficiently concerned about Mrs A to take a wound swab and ask the staff on the next shift to monitor Mrs A's temperature. Ms E should have arranged for an urgent medical consultation, or at least undertaken a comprehensive assessment including pulse, respiration and blood pressure recordings, chest auscultation and fluid balance recordings. There is no indication that Ms E considered any of these.

Accordingly, by failing to follow up the urine specimen and undertake a full assessment of Mrs A's health status, Ms E breached Right 4(1) of the Code.

Clinical record
Ms E's notes for 27 April recorded Mrs A's temperature and that she had been given Pamol. Ms E noted that she had redressed Mrs A's arm and taken a wound swab. The note about the wound swab was underlined. There is an additional note, which stated, "28/4 Add". The note described the state of the wound and arm and the type of dressing applied. When Ms E was interviewed by the rest home after Mrs A's death, she admitted that she had added this note when she returned to duty on the night of 28 April, after hearing that Mrs A had been taken to the public hospital. She told the police that she had made the additional note because she was concerned that there was no record of the skin tear, and no short-term care plan to assess the healing progress. In response to my provisional opinion, Ms E said that she had been too busy to record the information on 27 April.

In my view, Ms E's explanations are not convincing given that she found time on 27 April to record details of Mrs A's temperature, pain relief, food and fluid intake and wound dressing. The information she added the following day, that Mrs A's arm was "slightly sloughy … oedematous … warm and pink", was essential information, which the staff on the following shifts should have known about. By not recording her observations at the time, Ms E did not provide timely information to the next shift to alert staff to the deterioration in Mrs A's condition. Her actions did not meet the standard reasonably expected of a registered nurse, as set out in Performance Criteria 4.3 of the Nursing Council's "Competencies for registered nurse scope of practice".

In my opinion, in relation to her documentation of the care she provided to Mrs A, Ms E breached Right 4(2) of the Code.

Breach — Ms F

Standard of care
On 27 April, registered nurse Ms F worked the afternoon shift. At about 7pm a caregiver reported to Ms F that she was unable to rouse Mrs A. Ms F considered that Mrs A had experienced a transient ischaemic attack (a temporary mild stroke). Ms F

assessed Mrs A, noting her blood pressure to be "very normal for a person of her age", and her temperature to be 36.4°C, lower than it had been on the previous shift. Ms F recorded her conclusion in the clinical notes at the end of the evening, instructing the following staff to monitor Mrs A's temperature four hourly. Ms F did not record that she considered that a medical assessment or ongoing monitoring of Mrs A's level of consciousness was warranted. Neither did Ms F consider, in light of Mrs A's previously noted high temperatures, the possibility that there could be another cause for Mrs A's temporary loss of consciousness. Ms F assumed that Mrs A's temporary loss of consciousness was neurological, and therefore did not look further.

Dr Neville advised that registered nurses should apply a degree of critical thinking to any given situation. As previously mentioned, registered nurses should be aware that older adults vary in their responses to infection and fever. They may not show a rise in temperature as a response to infection. Dr Neville stated:

> "I would have expected that any sudden change in body temperature should always be investigated. … [T]emperature fluctuations in older people are potentially hazardous and immediate action is required. If I was a registered nurse in this situation where the patient's temperature suddenly changed from being high to within normal range, I would have checked the equipment, checked my technique."

In response to the provisional opinion, Ms F stated that she would have assessed the equipment if she had thought the reading did not match the clinical signs. She said that Mrs A was not exhibiting any signs of fever on 27 April.

Mrs A had been exhibiting symptoms that her health status was compromised for more than 24 hours when Ms F saw her on 27 April. Mrs A's temperature had been fluctuating, she had vomited, and there was documented concern that she might have a urinary tract infection. Because she was on four-hourly observations, and a wound swab had been taken that morning, it is likely that Mrs A would have been one of the patients identified at handover as being of concern.

Throughout Ms F's assessment of Mrs A at 7pm, her bandaged arm was resting on a pillow. Ms F recalled, when interviewed by the police, that she did not remove the bandages and there did not appear to be any change in the appearance of Mrs A's arm. Although caregivers Ms M and Ms O recalled that Ms F changed Mrs A's dressing, they did not say that they witnessed the dressing being done. Ms M stated that she did not tell anyone about her concerns about the swelling because she thought they "would already know". Ms M and Ms O recall that Mrs A's arm was oozing sufficiently to require the pillow her arm was resting on to be changed a number of times during that shift. However, there was nothing in the notes for that evening about the state of Mrs A's arm. Ms F only noted that the arm was elevated on a pillow. In response to the provisional opinion, Ms F stated that she was unaware of any change

to Mrs A's arm, and said that she would have changed the dressing if she had been told about the oozing.

I accept Ms F's statement that she did not remove the bandages from Mrs A's arm, but I do not accept that she was entirely unaware of the condition of the arm. Mrs A's arm injury was documented to be of concern. This, combined with Mrs A's fluctuating temperatures and the fact that there was no description of the wound in the notes, should have prompted Ms F to assess the status of Mrs A's wound. Dr Neville advised that, as there was no description of the wound in Mrs A's notes, Ms F should have removed the bandage and checked the wound. Furthermore, given the reports from the caregivers of substantial oozing and swelling, it is difficult to believe that the appearance of Mrs A's arm gave no cause for concern.

In my view, in light of the deterioration in Mrs A's condition, and her history of elevated temperatures over the previous 24 hours, Ms F should have considered the possibility of infection and performed a full assessment of Mrs A's health status, including inspection of her arm wound. I do not accept Ms F's lawyer's submission that Dr Neville's advice that Ms F should have changed and checked Mrs A's dressing was "not good advice on what is reasonable care". Ms F, in my view, failed to apply the degree of critical analysis that would be expected of a registered nurse in these circumstances, and did not apply basic nursing skills in terms of assessing the health of her patient.

By not undertaking an assessment of Mrs A's health status and not inspecting her wound, in my opinion Ms F breached Right 4(1) of the Code.

No Breach — Ms F

Clinical record
Dr Neville advised that the standard of Ms F's documentation was "extremely poor". He said that a full description of the wound, which included the wound site, size, shape, present condition/state of healing, pain and quality and quantity of the exudates, as well as any other defining features, should have been provided. Dr Neville said that a full description of the interventions undertaken in relation to the wound should have been noted in the Wound Progress and Dressing Record, as well as in the progress notes. However, Dr Neville's advice was based on the view that Ms F changed Mrs A's bandage.

Given my finding that Ms F did not remove Mrs A's bandage, it is my opinion that Ms F did not breach the Code in relation to her documentation.

Breach — Ms G

Registered nurse Ms G worked the night shift on 27/28 April.

Fever management
At the beginning of her shift, Ms F informed Ms G about Mrs A's condition over the previous eight hours. Ms G recalled that Ms F did not suggest monitoring Mrs A's vital signs four hourly, but Ms G decided to do so because of Mrs A's episode of unconsciousness. Ms G took Mrs A's temperature at 11.30pm and found it to be 37°C. When Ms G she took Mrs A's temperature, pulse and blood pressure at 2am Ms G found Mrs A's pulse to be rapid at 100 beats per minute, and her blood pressure to be 99/71mmHg. Ms G stated that Mrs A's blood pressure was "normal for an elderly person". At 5.45am Ms G again checked Mrs A and found that her pulse was still rapid at 102 beats per minute, and her blood pressure was 106/72mmHg. Mrs A's temperature was again 37°C.

Dr Neville advised that Ms G should have recognised the seriousness of Mrs A's condition given Mrs A's clinical history of raised and fluctuating temperature, potential urinary tract infection, and the signs of infection present in the skin tear on her arm. Dr Neville stated that there were two options available to Ms G in light of these factors — a conservative or an aggressive approach. To determine which approach to take, she should have undertaken a thorough assessment of Mrs A. Following the gathering of the data, Ms G should have prioritised the problems identified — the elevated temperature and potential arm infection. An aggressive approach would have been to seek urgent medical attention immediately. A conservative approach would have been to continue to check the state of Mrs A's arm, provide analgesia, and monitor her vital signs. The information provided indicates that Ms G decided on a conservative approach. She apparently did not consider that Mrs A's condition was serious, or that an aggressive plan was required. Dr Neville advised that the service Ms G provided to Mrs A, in relation to her nursing assessment, would be viewed with moderate disapproval by her peers.

In response to the provisional opinion, Ms G stated that if a temperature chart had been available, Mrs A's fluctuating temperature would have been more obvious. While that may be so, the absence of a temperature chart does not absolve Ms G from recognising that Mrs A's temperature patterns were concerning. In my view, the evidence of Mrs A's fluctuating temperature was readily available in the nursing records (in particular the progress notes).

Wound management
Ms G recalled that she checked Mrs A's arm at 2am and found that the wound was weeping serous fluid with a "slight blood/slight pus tinge". The arm was warm and pink but not swollen. Ms G recalled that an hour later Mrs A's arm was still elevated on a pillow, and the wound had not leaked through the bandage. Ms G removed the dressing from Mrs A's arm and cleaned the wound area with saline, but did not observe any change in the condition of Mrs A's arm.

However, caregiver Ms K recalled that when she checked on Mrs A at 2.30am and 3.30am she found that the discharge from Mrs A's arm had soaked through the bandages into the pillow. When Ms K held Mrs A's arm for Ms G to change the dressing, it was hot and discoloured and there was a collection of fluid under the skin from Mrs A's elbow to her wrist. Ms K drew this to the attention of Ms G, who did not respond. When Ms K checked Mrs A at 6.30am, before going off duty, she found that the pillow under Mrs A's arm was again soaked. Ms G assisted Ms K to change the pillow.

Ms G recalled that at handover at 7am on 28 April, she and a caregiver took Charge Nurse Ms I to see Mrs A. However, Ms I stated that this is not correct. When she first saw Mrs A at 7.10am, accompanied only by the two morning shift caregivers, Ms I recalled that she was so shocked at the appearance of Mrs A that she had to leave the room momentarily. Mrs A was semi-responsive, and her arm was twice its normal size and black and purple in colour.

It appears extremely unlikely that Ms G's recording of her observations of Mrs A's arm, and her later recollection that the arm was only "pink and slightly swollen", is accurate. I am inclined to accept the recollections of Ms K that this serious situation was evident at 2.30 and 3.30am, especially when Ms I's description of the arm at 7.10am is considered. Regardless of whether or not Ms G escorted Ms I into Mrs A's room at handover on 28 April, the fact remains that Ms G should have taken action earlier.

Response to deteriorating condition
When Ms K checked on Mrs A at 5am, Ms K found that Mrs A was having difficulty breathing. Ms K said that she notified Ms G of this change in Mrs A's condition, and accompanied Ms G to Mrs A's room. Dr Neville stated that when Ms G was made aware of this change in Mrs A's condition, she should have immediately assessed Mrs A's rate, rhythm and depth of breathing and then charted these findings in the clinical notes.

In response to the provisional opinion, Ms G stated that Ms K did not report to her any change in Mrs A's condition at 5am. However, I note that Ms K's account of this is verified by caregiver Ms J. Whatever the truth of the matter, Ms G reported that she checked Mrs A at 5.45am when she took her recordings. Even if Ms G's version of events is preferred, it does not seem credible that 95 minutes after she last reviewed Mrs A and found nothing abnormal about her condition, Mrs A had deteriorated to a point where she was barely conscious and her arm was severely swollen and discoloured. Given the clinical picture presenting at 7.10am, I prefer Ms K's recollection of Mrs A's state in the early hours of 28 April.

Ms G stated that she informed Ms I at handover that she was concerned about Mrs A, but did not discuss with her the need to call a doctor. Ms G was apparently unaware that Mrs A was seriously unwell. Ms G said, "I thought from the handover I was giving, the first thing [Ms I] would do would be to call a doctor without me having to

mention it." In response to the provisional opinion, Ms G stated that Mrs A's condition had been ongoing, and the staff on earlier shifts had had easier access to medical assistance than she had during the night. She had felt no need to seek that assistance because she did not consider Mrs A's condition to be an emergency, and felt that only a routine medical review of Mrs A's arm was required.

In my opinion, Ms G's inaction in the face of Mrs A's deteriorating condition was inappropriate. I accept Dr Neville's advice that "[Ms G] provided a barely adequate nursing service to this patient. There was a distinct lack of assessment, critical thinking and clinical decision-making evident." Accordingly, in my opinion, Ms G did not provide Mrs A with reasonable care and skill and therefore breached Right 4(1) of the Code.

Documentation
Only some aspects of Mrs A's condition were documented by Ms G: the recordings of temperature, pulse and blood pressure, the intervention provided to address the temperature (the administration of Pamol), the provision of fluids, and dressing changes. There was no mention of the breathing difficulties reported at 5am, the quality and quantity of the wound ooze, or a description of the wound management. Additionally, and most importantly, there was no indication of the seriousness of Mrs A's condition, and that she needed to be seen urgently by a doctor.

Accordingly, in my opinion, Ms G breached Right 4(2) of the Code, by failing to obtain, document, and communicate relevant information.

Breach — The Rest Home Organisation

The rest home organisation (the organisation) had numerous systems/written policies and procedures in place to guide staff in a variety of care issues applicable to these events, such as management of serious illness and wounds, and procedures for recording blood pressure, pulse, temperature and respirations. The organisation also addressed quality issues by having in place an organisational quality framework and quality action plan.

Dr Neville advised that although there were adequate systems in place at the time of these events, there was a lack of clinical leadership and mechanisms for monitoring the clinical policies and procedures and quality systems. Dr Neville stated:

> "It is my professional opinion that adequate systems were in place at the time of the incident. However, the mechanisms for monitoring these systems obviously were not. There appeared to be a lack of clinical leadership in the facility. [The rest home], and indeed all long term care facilities, should have expert clinicians to monitor and ensure the organisation's quality systems are implemented. In

> addition, expert clinicians would provide clinical mentoring and leadership to registered nurses who not only provide nursing care to older people but also oversee the work of caregivers. …
>
> It is my professional opinion that both the organisation, as well as the registered nurses working during the above period, are responsible. While [the rest home] had a quality plan in place there appeared to be little mechanisms present to see the plan materialise into action."

Dr Neville noted that the organisation has a staff education programme in place as a means of keeping staff current in clinical issues relating to older people. He said that staff education is only one means of keeping staff current, and advised that formal education should be mandatory for some staff, in particular registered nurses. Dr Neville advised that all residential care facilities need to include in their quality plans a mechanism for releasing staff to participate in formal education programmes.

One of the most striking aspects of this matter relates to the number of registered nurses involved in Mrs A's care. Dr Neville commented that the documentation provided to him identified each nurse as the Primary Nurse, but no one person was assigned to coordinate the care. He advised that a consistent registered nurse should have been assigned to Mrs A on a regular basis, to gain in-depth knowledge of her condition and develop a plan of her care needs. The other nurses attending Mrs A should have implemented the plan and reported to that nurse.

In response to the provisional opinion, the organisation provided additional documentation that shows that Ms F was the registered nurse assigned to be Mrs A's primary nurse. I agree to some extent with the organisation's contention that they were dependent on the registered nurses complying with the systems in place at the rest home and using their professional skills to provide a reasonable standard of care. However, it is clear that the nurses involved in Mrs A's care over the weekend of 26 to 28 April did not provide that level of care. In response to the provisional opinion, their lawyer (on behalf of Ms E, Ms F and Ms G) and Ms D suggested that a number of the failings of the nurses were the result of understaffing. I understand that in response to the concerns raised by the registered nurses following these events, an additional charge nurse position has been established, and there are now two registered nurses employed on the afternoon shift. Changes have been made to the policies and procedures, to clarify the organisation's expectation of the delivery of care.

As Dr Neville stated, there were a series of unfortunate oversights in terms of the care provided to Mrs A between 23 and 28 April. These oversights resulted in an "unfortunate negative trajectory of events", which led to Mrs A's death. Standard 2.7 of the New Zealand Health and Disability Sector Standards states that organisations must ensure that consumers receive timely, appropriate and safe services from suitably skilled service providers. In my view, by failing to have in place a formal education programme for staff, and failing to have appropriate clinical monitoring and

supervision of the quality management system, the rest home organisation did not comply with this standard.

Accordingly, in my opinion, the rest home organisation did not provide services that comply with the relevant standards, and thus breached Right 4(2) of the Code.

Other comment

Commissioner's investigation
In her response to the provisional opinion, the Ms E's, Ms F's and Ms G's lawyer raised a number of concerns about the Commissioner's investigation.

Ms I's lawyer submitted that Ms I, as charge nurse/team leader, was responsible for the continuity and co-ordination of Mrs A's care, and suggested that based on the precedents set out in another Opinion (01HDC11139), Ms I should have been investigated. However, the focus of this investigation was on the events that occurred between the afternoon of 25 April and the morning of 28 April. This was the period when the septicaemia set in and Mrs A was recorded as having a raised temperature. Ms I was not working over this period. The systems issues identified have been addressed through the investigation of the rest home. Therefore I am satisfied that the appropriate providers were investigated given the timeframe of the relevant events.

Actions taken

Ms D
Ms D has provided a written apology to Mrs B.

Ms C
Ms C has provided evidence of the further training in the care of aged people that she has since undertaken.

Recommendations

I recommend that Ms C:

- apologise for her breach of the Code. A written apology should be sent to the Commissioner for forwarding to Mrs B.

I recommend that Ms E:

- apologise for her breach of the Code. A written apology should be sent to the Commissioner for forwarding to Mrs B.
- review her practice and undertake further training in the care of older people.

I recommend that Ms F:

- apologise for her breach of the Code. A written apology should be sent to the Commissioner for forwarding to Mrs B.
- review her practice and undertake further training in the care of older people.

I recommend that Ms G:

- apologise for her breach of the Code. A written apology should be sent to the Commissioner for forwarding to Mrs B.
- review her practice and undertake further training in the care of older people.

I recommend that rest home organisation:

- apologise for its breach of the Code. A written apology should be sent to the Commissioner for forwarding to Mrs B.
- review its organisational quality framework in light of Dr Neville's comments and this report.
- provide this Office, by 24 October 2006, with evidence that changes that have been made as a result.

Follow-up actions

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

- A copy of my final report will be sent to the Nursing Council of New Zealand, the Ministry of Health, and the District Health Board.

- A copy of my final report, with details identifying the parties removed, will be sent to HealthCare Providers New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, on completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings considered the matter and decided not to issue any proceedings. Whilst the conduct of Nurses F and G had clearly fallen below reasonable standards, the evidential difficulties in proving all relevant matters to the requisite standard some time after the event meant that the likelihood of having a disciplinary charge or civil claim upheld was not sufficiently strong to justify bringing proceedings. The failures of the nurses did give rise to concern about their practice and public safety and, accordingly, the Director referred them both to the Nursing Council for competence review.

Appendix A

POSITION DESCRIPTION

POSITION TITLE:	Registered Nurse
LOCATION:	
DATE:	19TH July 2001
RESPONSIBLE TO:	Principal Nurse Manager

DIRECT REPORT	Caregivers
FUNCTIONAL RELATIONSHIPS	Principal Nurse Manager Support Services Staff Quality Assurance/Training Coordinator Administration Officer Services Officer Village Residents, Family, Friends and Visitors Contractors Volunteers Community Groups

PURPOSE The purpose of the position is to:-

(a) Under the direction of the Principal Nurse Manager, efficiently and effectively deliver a high standard of care to Residents which will optimize their quality of life and;

(b) Supervise and provide clear direction to Care Staff placed under the Registered Nurse's direct control to enable them to achieve their goal of quality care.

KEY RESULTS

- The Principal Nurse Manager is kept fully informed on all aspects of the Registered Nurse's area of responsibility that require senior level consultation and/or direction.
- Demonstrate commitment to quality service including:-
  - communicating with residents in a friendly, professional manner
  - ensuring timely, accurate and effective delivery of service
- Assist the Principal Nurse Manager to ensure quality recruitment of care staff.
- General functions including staff management are carried out efficiently.
- All policies, procedures and standards that are developed, in particular those for the Quality Health New Zealand Standards, are adhered to.

DATE: 30/01/02 PAGE 1 OF 3
REVISION NO: 2 AUTHORISED BY:
DOCUMENTID: QHNZ 2001: STD NO: HR4.0

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

KEY TASKS AND ACCOUNTABILITIES

1. Attain and maintain the proper standards of care and well being for all residents.

- Care plans are maintained accurately.
- Each person introduced to residential care is treated sensitively.
- Consult with resident (and family where appropriate) to identify needs.
- Resident's privacy and dignity is maintained at all times.
- Assist the Principal Nurse Manager to assess the ability of residents to cope with daily living and encourage their independent behavior.
- Provide supervision for care staff under the Registered Nurse's direct control to ensure they provide appropriate care for residents and are aware of the importance of residents' rights.
- Advise the Principal Nurse Manager as appropriate to ensure regular medical assessments of residents are undertaken.
- Assist the Principal Nurse Manager as required to order prescribed medicines and maintain the proper function of the medication system including safe storage.

2. Staffing

- New care staff have relevant skills and qualifications commensurate with the positions in which they are employed.
- All care staff under the Registered Nurse's supervision proceed through a recognized orientation programme.
- Position descriptions are reviewed annually.
- Staff appraisals are undertaken annually.
- Disciplinary action is taken where necessary and within policy.

3. Quality Assurance

- Maintain and demonstrate an ongoing commitment to Quality Assurance.
- Review QA plans and policies in conjunction with the Principal Nurse Manager and QA Co ordinator.
- Actively implement quality care for Residents.

4. Training

- In conjunction with the Principal Nurse Manager implement regular staff training programmes for care staff under the Registered Nurse's direct control.
- Ensure staff are trained in all aspects of care for the older person.
- Keep up to date with legislative and clinical developments relating to care of the elderly.

5. Safety

- Demonstrate understanding of Health and Safety requirements including the reporting of any identified safety hazards.
- Demonstrate knowledge of evacuation procedures.
- Able to locate and use fire extinguishers.
- Continue to up-date First Aid knowledge and practice.

6. Supervision

- Provide effective leadership to care staff under direct control.
- Communicate effectively and ensure reporting requirements are met.

DATE: 10/04/02 PAGE 2 OF 3
REVISION NO: 2 AUTHORISED BY:
DOCUMENTID: QHNZ 2001: STD NO: HR4.0

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7. General

- Ensure full compliance with the Privacy Act.
- In consultation with the Principal Nurse Manager as necessary, ensure the correct procedures are followed in dealing with complaints.
- Ensure all services provided to the Residents are spiritually and culturally appropriate through maintaining awareness of the principles of the Treaty of Waitangi and all relevant cultural issues.
- Professional standards are maintained through self-development and attendance at appropriate courses.
- Maintain a working knowledge of relevant legislation.
- Provide the Principal Nurse Manager with advice and/or assistance as may be required.
- Carry out any other duties as required by the Principal Nurse Manager from time to time.

STAFF APPRAISAL

Three months after initial employment then annually or more frequently if requested by either party.

DATE: 30/01/02 REVISION NO: 2 AUTHORISED BY: PAGE 3 OF 3

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Appendix B

NOTES FOR WOUND ASSESSMENT

1.	TYPE OF WOUND:	LACERATION; SKIN TEAR; PRESSURE ULCER; VENOUS ULCER, ETC
2.	LOCATION:	ACCURATE DESCRIPTION, eg OUTER ASPECT OF LEFT ANKLE
3.	WOUND SIZE:	APPROXIMATE DIMENSIONS IN MM'S
4.	DEPTH SCORE:	1: SUPERFICIAL/EPIDERMAL DAMAGE 2: EXTENDING TO DERMAL LAYER 3: EXTENDING TO SUBCUTANEOUS LAYER 4: EXTENDING TO MUSCLE/TENDON/BONE 5: EXTENDING TO CAVITIES
5.	EXUDATE VOLUME:	SMALL / MEDIUM / LARGE
6.	COLOUR OF EXUDATE:	CLEAR / BLOOD / PUS
7.	QUALITY OF SURROUNDING SKIN:	HEALTHY / INFLAMED / MACERATED / EXCORIATED / FRIABLE / DRY / CRUSTY / FRAGILE
8.	ODOUR:	NONE / SOME / OFFENSIVE
9.	PAIN:	NONE / AT DRESSING CHANGE / INTERMITTENT / CONTINUOUS
10.	NUTRITION:	VERY UNDERWEIGHT / UNDERWEIGHT / HEALTHY / OVERWEIGHT / OBESE
11.	DIABETES:	IF YES, STATE TYPE, eg DIET CONTROLLED, TABLET CONTROLLED, INSULIN DEPENDENT
12.	BLOOD SUPPLY:	GOOD / POOR, eg SIGNIFICANT DIFFERENCE BETWEEN ARM AND LEG CIRCULATION
13.	HEALTH PROBLEMS:	SIGNIFICANT TO WOUND HEALING, eg ANAEMIA, RESPIRATORY DISORDERS ETC
14.	MEDICATION:	THOSE WHICH MAY AFFECT WOUND HEALING, eg STEROIDS, IMMUNOSUPPRESSANTS, CHEMOTHERAPY ETC.

DATE: 02-04-02
DOC ID: SC NOTES FOR WOUND ASSESSMENT

REVISION NO. 2
QHNZ 2001 SC 6.0

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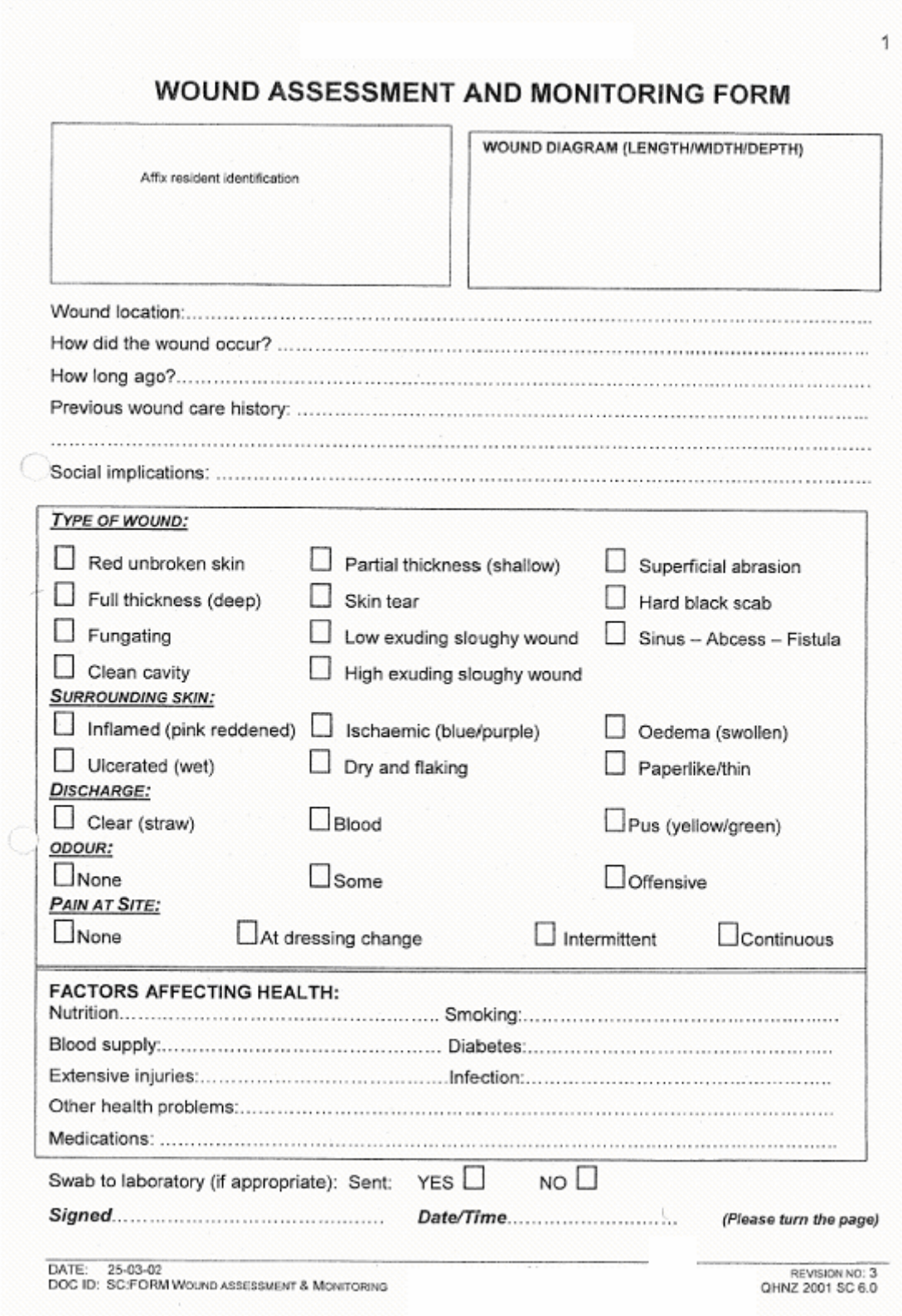

1

WOUND ASSESSMENT AND MONITORING FORM

Affix resident identification

WOUND DIAGRAM (LENGTH/WIDTH/DEPTH)

Wound location:.....

How did the wound occur? .....

How long ago?.....

Previous wound care history: .....

.....

Social implications: .....

TYPE OF WOUND:

☐ Red unbroken skin ☐ Partial thickness (shallow) ☐ Superficial abrasion

☐ Full thickness (deep) ☐ Skin tear ☐ Hard black scab

☐ Fungating ☐ Low exuding sloughy wound ☐ Sinus – Abcess – Fistula

☐ Clean cavity ☐ High exuding sloughy wound

SURROUNDING SKIN:

☐ Inflamed (pink reddened) ☐ Ischaemic (blue/purple) ☐ Oedema (swollen)

☐ Ulcerated (wet) ☐ Dry and flaking ☐ Paperlike/thin

DISCHARGE:

☐ Clear (straw) ☐ Blood ☐ Pus (yellow/green)

ODOUR:

☐ None ☐ Some ☐ Offensive

PAIN AT SITE:

☐ None ☐ At dressing change ☐ Intermittent ☐ Continuous

FACTORS AFFECTING HEALTH:

Nutrition..... Smoking:.....

Blood supply:..... Diabetes:.....

Extensive injuries:..... Infection:.....

Other health problems:.....

Medications: .....

Swab to laboratory (if appropriate): Sent: YES ☐ NO ☐

Signed..... ***Date/Time***..... ***(Please turn the page)***

DATE: 25-03-02
DOC ID: SC:FORM WOUND ASSESSMENT & MONITORING

REVISION NO: 3
QHNZ 2001 SC 6.0

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2

WOUND PROGRESS AND DRESSING RECORD

DATE	STAGE OF HEALING	AMOUNT OF EXUDATE	DRESSING USED	NEXT DRESSING CHANGE DUE	INITIALS

DATE: 25-03-02
DOC ID: SC:FORM WOUND ASSESSMENT & MONITORING

REVISION NO: 3
QHNZ 2001 SC 6.0

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TEMPERATURE MEASUREMENT

AXILLARY TEMPERATURE

SPECIAL NOTE

The axillary route, a temperature-sensitive strip, or the tympanic membrane is the preferred method of evaluating the body temperature of a child younger than 6 years. These should also be the methods of choice for a confused or disoriented adult.

Reinforce differences in temperature reading depending on route used. Axillary temperature is generally a degree less than an oral measurement; a rectal temperature is usually a degree higher.

OBJECTIVE

To find out an individual's body temperature when it is impractical to use the oral method.

REQUIREMENTS

- Thermometer.
- Soft tissue.

PROCEDURE

1) Preparation

- Wash and dry hands.
- Collect thermometer in container.
- Take equipment to the bedside.
- Explain the procedure to the resident / Ensure resident's privacy.

2) Technique

- If thermometer has been stored in a chemical solution, wipe it dry with a tissue.
- Ensure that the mercury level is 36 degrees Centigrade or less.
- Place the thermometer under the resident's arm, in the axilla. Ensure that the skin surface is dry and that the skin is in contact with the bulb of the thermometer.
- Leave the thermometer in position for 5 minutes.
- DO NOT LEAVE RESIDENT UNATTENDED.
- Remove the thermometer.
- Read the thermometer.
- Shake down the mercury level.

Signature ———— Issue date ———— Issue No. ———

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