Ellora Enterprises Limited
(trading as Sheaffs Rest Home)

Rest Home Manager, Ms B

Registered Nurse, Ms D

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC00423)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. In early 2011, Mr A, then aged 77 years, was discharged from hospital to Sheaffs Rest Home. Mr A had been treated at the hospital for a chest infection and dehydration. He had also been assessed as being depressed and was commenced on an antidepressant.

2. Sheaffs Rest Home is a privately owned facility that cares for up to 29 residents. At the time of these events, staffing at Sheaffs Rest Home included: a facility manager who had overall responsibility for services; a part-time registered nurse who was responsible for assessing residents, developing and updating care plans, medication management, and providing and supervising care; an enrolled nurse who was responsible for working with the registered nurse to prepare comprehensive care plans for residents and providing and supervising care; and caregivers.

3. When Mr A was admitted to Sheaffs Rest Home, the Facility Manager completed half the Admission Form, and the registered nurse assumed responsibility for completing the initial nursing assessment and care plan. The initial nursing assessment was not completed because the registered nurse was not able to talk to Mrs A, which was required as part of the assessment. However, the registered nurse completed a detailed care plan. The care plan identified Mr A's risks associated with poor diet and food intake due to depression, and noted a number of interventions to manage that risk, including weekly weighs, reporting changes in his appetite, and starting a food chart when his appetite decreased. He was noted to have a wound on his right shin.

4. The clinical records indicate that over a period of five days, 12 days after his admission to the rest home, Mr A's mood was low and he frequently refused food or fluids, or took only a few spoonfuls of food. Staff did not initiate interventions as set out in Mr A's care plan. There was no evidence that changes in his appetite were reported, that a food chart was commenced, that a weekly weigh was undertaken, or that further medical or nursing reviews were requested. At the request of Mr A's family, he was admitted to hospital, where he was found to be frail and dehydrated, and to have had a myocardial infarction (heart attack). Mr A passed away a few days later.

Deputy Commissioner's findings

5. Although the care plan written by the registered nurse reflected Mr A's needs and was appropriate, the registered nurse used a flawed process in the development of that plan. In particular, the nursing assessment on which the plan was based was not completed, and the registered nurse documented that the care plan was developed with input from Mr A's family when it clearly had not been. Furthermore, although there was no evidence that Mr A's medication was administered incorrectly during his time at Sheaffs Rest Home, Mr A's medication management was not aligned to best practice because there was a delay in the GP signing Mr A's medication sheet, as required by the rest home's policy and the Ministry of Health's Guideline "Safe Management of Medicines" (1997).

6. The registered nurse's care of Mr A fell below expected standards, and she breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights 1996 (the Code).

7. The Facility Manager had overall responsibility for ensuring a quality service was provided to Mr A at Sheaffs Rest Home. She failed in that responsibility in that she did not ensure that staff complied with Mr A's care plan, did not ensure Mr A was reviewed by a nurse or doctor when his condition deteriorated, and deliberately chose to wait until Mr A's next general practitioner appointment to have Mr A's medication sheet signed. The Facility Manager also breached Right 4(1) of the Code.

8. Sheaffs Rest Home breached Right 4(1) of the Code, because it failed in its responsibility to ensure that staff complied with policies and provided services of an appropriate standard to Mr A. Sheaffs Rest Home also breached Right 4(2)[2] of the Code, because its documentation in this case was suboptimal.

Complaint and investigation

9. The Commissioner received a complaint from Ms C about the services provided to her father, Mr A, at Sheaffs Rest Home. The following issues were identified for investigation:

- *Whether Ellora Enterprises Ltd trading as Sheaffs Rest Home provided Mr A with an appropriate standard of care in early 2011.*
- *Whether Ms B, Manager Sheaffs Rest Home, provided Mr A with an appropriate standard of care in early 2011.*
- *Whether registered nurse RN D provided Mr A with an appropriate standard of care in early 2011.*

10. An investigation was commenced on 27 February 2012.

11. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Mr A's wife
Ms B	Manager and co-owner of Sheaffs Rest Home
Ms C	Complainant and Mr A's daughter
Sheaffs Rest Home	Provider
RN D	Registered nurse
EN E	Enrolled nurse

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Also mentioned in this report:

Dr F	General practitioner
Ms G	Needs assessor
Ms H	Caregiver
Dr I	Hospital physician
Dr J	Hospital physician

12. Information was reviewed from: Mr A's family, Sheaffs Rest Home, the hospital, and general practitioner (GP) Dr F.

13. Independent expert advice was obtained from registered nurse Ms Sylvia Meijer, and is attached as **Appendix A**.

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

Information gathered during investigation

Background

The hospital

15. Mr A had multiple health concerns, including aortic stenosis, congestive heart failure, type II diabetes, diverticulosis, and chronic right leg osteomyelitis. He lived at home with his wife, Mrs A. Mr A had multiple hospital admissions in 2010.

16. In early 2011, Mr A (then aged 77 years) was admitted to the hospital, where he was treated for a chest infection and dehydration. He was also assessed as depressed, and commenced on an antidepressant (paroxetine).

17. At a family meeting it was decided that Mr A would be referred to the local needs assessment agency for an assessment with a view to his admission into residential care. Mr A was assessed as eligible for residential care at rest home level.

18. Mr A was assessed by a psychogeriatrician who recommended that Mr A continue the paroxetine. The psychogeriatrician also noted: "Wife to get [Power of Attorney], he understands and agrees (capacity present)."

19. Mr A was discharged from the hospital to Sheaffs Rest Home.

Sheaffs Rest Home

20. Sheaffs Rest Home provides care for up to 29 residents. To provide context to the care and treatment Mr A received at Sheaffs Rest Home, it is necessary first to understand the staffing structure of the rest home and the relevant admission policies.

Sheaffs Rest Home — staffing

21. At the time of these events, Ms B was the Facility Manager. She had been the manager since the early nineties, with a break for further study. According to her job description, Ms B's responsibilities as manager included ensuring all statutory and contractual obligations were met, ensuring all clinical and non-clinical services at Sheaffs Rest Home were delivered to clients in a safe and dignified way, managing and maintaining supervision of clinical and non-clinical services, and ensuring services were acceptable to each client.

22. At the time of these events, registered nurse RN D worked part time at Sheaffs Rest Home. RN D advised that her role was to fulfil the obligations to the rest home under the Age Related Residential Care Services Agreement, and that this was "largely an advisory role". RN D's duties included assessing residents on admission or when their level of dependency changed, developing and updating care plans, medication management (including advising on care and medication administration), providing and supervising care, discussing care plans, policies, and incident and accident forms with staff, monitoring the competence of other nursing and care staff to ensure safe practice, and assisting in the development of policies and procedures. RN D also worked at the hospital. Her shift times at Sheaffs Rest Home were variable, to fit with her hospital shifts.

23. At the time of these events, enrolled nurse (EN) E worked full time at Sheaffs Rest Home, from 7am to 3.15pm, Monday to Friday. In accordance with her job description, EN E was responsible for working with the registered nurse to prepare comprehensive care plans for each resident, drug administration, providing and supervising care of residents, ensuring that (in the absence of the registered nurse or manager) new admissions were welcomed and settled in and all necessary documentation was completed, maintaining clinical records, and training staff to ensure they adhered to care plans.

24. Sheaffs Rest Home also employs a number of caregivers and a diversional therapist, along with kitchen and cleaning staff. According to the caregiver job description, caregivers were responsible for delivering home help care safely, efficiently, and effectively.

Sheaffs Rest Home — admission policies

25. Sheaffs Rest Home's policy in relation to Resident Admission (dated December 2010) states:

> "**Procedure**
>
> …
>
> 2. A nursing assessment is completed together with resident/relative/agent. Each resident['s] personal and health needs are assessed on admission and the ongoing evaluation process ensures that assessments reflect the resident's current status. This assessment will utilize information gained from the resident, the nominated

representative and that provided by the referring agency and/or previous provider of health and personal care services along with observations and examinations …

- Following 1–3 weeks of observation and feedback from staff a more definite care plan is developed after, Resident, family, whanau, agent and GP involvement is encouraged (sic). All care plans are reviewed every six months or more often if resident's circumstances or condition changes.

3. Resident profile will be completed within 24 hours of the resident's admission.

4. On admission, new residents and their risk of developing pressure areas will be assessed against the Norton scale. The results of which will be documented and the necessary measures to minimize the risk will be implemented and documented in the resident's care plan. …"

26. Sheaffs Rest Home's policy in relation to admission documentation (dated December 2010) states:

"**Admission form (part of integrated file)**

- This form must be completed on the day Resident is admitted by the designated nurse or person in charge.

…

Resident Medical Data Form (part of integrated file)

- This is to be completed by a Registered Nurse/Manager or designated person. Information can be obtained from: hospital discharge forms, old medical records and residents or relatives. It is important to take baseline recordings i.e. blood pressure, temperature, pulse, respiration, weight and BM (for diabetics). These are very useful when Medical Staff are trying to ascertain weight loss/gain etc.

Registered Nurse Assessment (part of integrated file)

To be filled out by the registered nurse as soon as possible after admittance (no longer than three days following admittance date). And the on-going evaluation process ensures that assessments reflect the resident's current status.

Initial care plans (part of integrated file)

On admission this assessment will utilise information gained from the resident, the nominated representative and that provided by the referring agency and/or previous provider of health and personal care services along with observations and examinations carried out.

Following 1–3 weeks of observation a more definite care plan is filled in after feedback from nursing staff.

Resident Assessment Form/Care Plan (part of integrated file)

… The assessment is the most important foundation on which to build a good plan. Resources should include the Resident, relatives, caregivers and old notes. Basic observation skills of physical ability and agility are very important …"

27. Sheaffs Rest Home's policy in relation to resident assessment and reassessment (dated December 2010) states:

"**Policy**

Residents entering our facility are first assessed by an appropriate GP and/or psychogeriatric evaluation …

Procedure

1) All subsidized residents are accompanied by a Support Needs Assessment

2) The Resident should arrive with either Hospital notes or a referral letter which can be used as a resource for the Nursing Care Plan …

3) GP will provide a review within 48 hours of admission, unless resident is admitted from another clinical setting and has been seen by a Doctor prior to transfer

4) A comprehensive admission Nursing Assessment is completed with assistance of resident and family/advocate …"

28. Sheaffs Rest Home's policy in relation to residents' progress notes states:

"Primary care giver is to document in progress notes at least weekly at the end of a shift or [as required].[3]

Documentation in progress notes should occur as soon as practicable after any event/interaction with the resident. Document as frequently as indicated by the clinical condition of the resident. Changes in condition must be documented.

…

Progress notes should report on key aspects of care. Not all aspects need to be reported on for every shift; however there should be a continuous record of interventions, signs and symptoms or events of issues."

Mr A's admission to Sheaffs Rest Home – Day 1

29. Mrs A recalls that she and her husband arrived at Sheaffs Rest Home at about 4pm. Ms B introduced Mr and Mrs A to the home, and admitted Mr A.

30. Mrs A recalls that Ms B asked Mr A questions, including questions about his food preferences, and she took a photo of Mr A. Mrs A also advised that Ms B told her and

[3] Ms B advised that the "primary caregiver" in this context is the enrolled nurse.

her husband that Sheaffs Rest Home has its own general practitioner (GP), and that if Mr A wanted to see his GP a charge would be involved. Accordingly, Mrs A advised that they decided to use Sheaffs Rest Home's GP. Mrs A recalls that she left Sheaffs Rest Home at approximately 5.45pm and at that time Mr A was in his room and was reasonably bright and happy.

Admission Form — Ms B

31. Ms B received copies of Mr A's hospital Discharge Summary, an Inter-Hospital Transfer form, and a prescription form.

32. The Discharge Summary stated that Mr A's vitamin K levels were to be checked in ten days' time, and that his vitamin B_{12} and folate levels, which had been high, should also be checked. It was noted that Mr A had had a depressed mood during his hospital stay, which had affected his appetite, and that Mr A required GP follow-up in two weeks' time. The Inter-Hospital Transfer form noted Mr A's recent observations, including his weight of 70.8kgs. It noted that he had a normal diet with Diasip[4] while in hospital, he needed assistance with his self-cares, he used a frame as a mobility aid,[5] and his skin was intact.

33. Ms B and EN E recall that prior to Mr A's admission, they had also obtained information about Mr A from conversations with Mrs A and needs assessor Ms G.

34. Ms B completed the first page of an Admission Form, and noted in the progress notes:

> "New resident discharged from hospital. Diabetic but has been on normal diet. One Diasip after meals x3. Medication arriving in the morning. Shower odd mornings. Has a small wound that will need dressing."

35. Ms B did not complete the second page of the Admission Form, which was used to record medical information. She states that she was happy to use the discharge observations taken that day at the hospital and documented on the Inter-Hospital Transfer form.

Initial nursing assessment — RN D

36. RN D advised that when a new resident was admitted to Sheaffs Rest Home, it was usual practice for EN E to complete the initial nursing assessment. RN D would then complete the full nursing assessment and care plan within the following few days.

37. RN D recalls that she was aware of Mr A's planned admission. As EN E was on leave, RN D arranged to come in at 4.30pm after her shift at the hospital, to complete Mr A's initial nursing assessment and care plan.

38. RN D stated that by the time she met with Mr A that afternoon, Mrs A had already left.[6] RN D said that she asked Mr A some general questions about how he was

[4] Diasip is a nutritional supplement specifically formulated for people with diabetes.
[5] Mrs A advised HDC that Mr A never walked with a frame.
[6] As noted above, Mrs A told HDC that she left Sheaffs Rest Home at 5.45pm and would have been happy to have provided input into her husband's care plan prior to leaving that day. She advised HDC

feeling and how he got around, before returning to the office to complete the assessments and care plan. RN D stated that in order to complete the nursing assessment and care plan that day she drew on information from several sources, including:

- her conversation with Mr A;
- Mr A's Discharge Summary and the Inter-Hospital Transfer form;
- an informal conversation earlier in the day with the hospital colleagues who had been looking after Mr A on the ward; and
- conversations with Ms B and EN E prior to Mr A's admission, relaying information they had obtained from speaking with Mrs A and Ms G.

39. Records show that on Day 1, RN D completed a care plan (see below), a Barthel Index,[7] a falls risk assessment, a continence assessment, and an assessment of pressure area risk using the Norton scale. RN D advised HDC that she did not finish the nursing assessment that afternoon, as it was her intention to do this after she had had the opportunity to speak with Mrs A.

40. Mrs A stated that at no stage during her husband's time at Sheaffs Rest Home did she communicate with RN D about her husband's care, assessment or deterioration.

Initial care plan — RN D

41. On Day 1, RN D completed a detailed, nine-page care plan. RN D explained that rather than complete the initial, one-page care plan that would usually be completed on admission, she completed a full care plan. She stated that she sometimes did this on the basis that if the care plan was correct or required minor adjustments only, it could save time "further down the track". She said that it also allowed for the completion of a more detailed care plan. She stated that if she completed a full care plan at the outset and later found that it required a lot of changes, she would write a new one.

42. RN D wrote on the care plan that it had been completed with input from Mrs A and Ms G. When HDC asked RN D about this, she stated:

> "I had intended to catch-up with [Mr and Mrs A] to complete the assessment in the coming days however I was informed by [Ms B] that [Mrs A] was away. Since the initial care plan can cover a period of up to three weeks I would have made an appointment with [Mrs A] to complete the assessment and finalise care plans during the week after my return to work on [Day 18]."[8]

43. Mrs A advised HDC that the only time she was away was on Days 12 and 13.

---

that she could have come back to Sheaffs Rest Home if she had been asked to, to provide input into the care plan.

[7] The Barthel Index is a scale to measure a person's performance in activities of daily living.

[8] RN D was on leave from Day 12 to Day 17.

44. The care plan RN D completed for Mr A identified a number of issues in relation to his care, including:

- risk of skin breakdown due to incontinence and lack of mobility;
- high falls risk;
- poor diet and food intake due to depression, with weight loss; and
- depression — affecting mobility, food intake, toileting, social isolation, and awareness of surroundings.

45. With regard to Mr A's diet, food intake, and weight loss, RN D noted the following interventions:

> "Encourage [Mr A] to feed himself as much as possible. Feed [Mr A] as needed.
>
> [Mr A] to be weighed [once a week].
>
> Report changes in [Mr A's] appetite.
>
> [Mr A] will have no less than 6 (250mls) glasses of fluid a day.
>
> Provide [Mr A] with food that [he] enjoys.
>
> [Mr A] will have 3 meals a day, and morning, afternoon tea, and supper.
>
> [Mr A] is to have 3 Diasip drinks a day.
>
> Start food chart when [Mr A's] appetite is decreased."

46. RN D also noted on Mr A's care plan: "Monitor sinus on [right] shin and redress as needed note any changes."[9] RN D cannot recall whether she saw the sinus on Mr A's leg that day, or exactly how she was alerted to it. She stated that hospital staff or Mr A may have mentioned it. RN D recalls that it was not a major wound, and that initially it did not require dressing.

47. In relation to Mr A's diabetes, RN D wrote: "Administer oral diabetic medication as prescribed." Mr A had not been prescribed any diabetic medication.

48. After reviewing the "facts gathered" section of my provisional opinion, Mrs A and her daughter, Ms C, raised concerns about the accuracy of RN D's care plan for Mr A. In particular, Ms C noted that, contrary to what is recorded in the care plan, her father was continent, independently mobile, and able to feed and toilet himself.

No initial GP involvement

49. As noted above, Sheaffs Rest Home policy required new residents to be reviewed by a doctor within 48 hours of admission, unless the resident was being admitted from another clinical setting and had been seen by a doctor prior to transfer.

[9] A sinus is a cavity within bone or other tissue.

50. Ms B stated that as the hospital Discharge Summary had asked for GP follow-up in two weeks' time, she decided to wait before arranging a GP visit. This allowed for the blood tests requested by the hospital to be obtained.

Medication management

51. At the time of these events, Sheaffs Rest Home's "Medicines Safety Management Protocol" stated:

> "**How do we ensure appropriate medication reconciliation?**
>
> - On admission we establish the resident's medication history and seek information from the referrer or previous GP.
>
> - The prescribed medication is documented on medication administration chart and signed by GP to authorise the documented medicines. …"

52. Ms B advised that the prescription form from the hospital was faxed to a pharmacy. The pharmacy then generated a medication profile and a signing sheet, which would have been delivered to Sheaffs Rest Home with Mr A's medication the following day (Day 2). Ms B stated that she checked off the medications with the medication sheet ("Medicine Chart") from the pharmacy (ie, she reconciled the medication); however, she decided to wait until Mr A's next doctor's appointment to have the medication sheets signed by the GP.

53. In response to the provisional opinion, RN D advised that she was not aware that Ms B had chosen to dispense the medication from the unsigned medication chart, and she had no reason to check the medication chart in the following days.

Care at Sheaffs Rest Home

Days 2-11

54. There is a brief entry in the progress notes for Day 2. No entries were made on Day 3 and Day 4.

55. Caregiver Ms H recalls that while providing care to Mr A on Day 5, she noticed a wound on his right leg and reported this to RN D. RN D stated that she and Ms H assessed and dressed the wound. Ms H noted on a "Wound Assessment and Treatment Form": "Cleaned with saline, aquacel, telfa dressing, smells and it's green. To do daily." Ms B also documented reference to the wound in the progress notes, which also stated that the wound needed to be dressed daily with Aquacel and a dry dressing. Records show that Mr A's wound was cleaned and redressed by caregivers on Days 6, 8, 9, 10 and 11.

56. On Day 5, Mr A's blood sugar levels were checked for the first time since his admission.

57. No entry was made in the progress notes on Day 6. On Day 7 it was noted that Mrs A had taken Mr A to hospital for an appointment.

58. On Day 8, Mr A's needs assessment was faxed to Sheaffs Rest Home. RN D advised HDC that had she had access to this before Mr A was admitted, she would have recommended him for hospital level care. The needs assessment recorded that Mr A tolerated a normal diet, but that "loss of appetite is a factor". It also stated: "Lack of interest in meals and poor intake of both food and fluids is recorded in the client notes." There is no indication of any adjustments being made to Mr A's care plan on receipt and review of the needs assessment at Sheaffs Rest Home.

59. Entries in the progress notes on Day 8 and Day 9 refer to Mr A being "depressed", "sad", and "apathetic". On Day 8, a caregiver noted: "Refused tea just had his diasip."

60. Ms C stated that on Day 8 or Day 9, her family were concerned that Mr A had a sore throat and was having difficulty swallowing. She recalls that she reported this to Ms B.

61. Ms B stated that on the day of Mr A's admission to Sheaffs Rest Home, there had been some discussion with Mrs A about her husband possibly having a bit of a sore throat because of a recent gastroscopy, but no discussion about this stopping him from eating. Ms B does not recall being informed subsequently that Mr A had a sore throat or that he was having difficulty swallowing.[10] In response to the provisional opinion, Ms B further noted that Mr A's needs assessment, dated Day 7 and faxed to Sheaffs Rest Home on Day 8, stated: "While tolerating a normal diet loss of appetite is a factor. Client states that he has no difficulty with swallowing food however he does sometimes have a problem with his pills."

62. RN D worked five shifts at Sheaffs Rest Home between Day 2 and Day 11. She was then on leave for six days. Ms B advised that Sheaffs Rest Home did not replace RN D during this period, as they can use the doctors, GP practice nurses, or the hospital if registered nurse input is required.

General practitioner review

63. EN E had been on leave for two weeks from three days prior to Mr A's admission.[11] She recalls that when she returned to work on Day 12, she found that Mr A was not eating well, and that he seemed depressed.

64. EN E arranged for Mr A to be seen that day by general practitioner Dr F.[12] EN E told HDC that as far as she can recall, she requested Dr F to review Mr A because all new residents need to be seen by a doctor within a fortnight of admission, and Mr A had yet to be seen.

[10] Ms B reiterated in her response to the provisional opinion that Sheaffs Rest Home staff were not told that Mr A had a dry throat.
[11] Ms B advised that an extra caregiver had been employed during this period.
[12] At the time of these events, Dr F provided GP services to residents at Sheaffs Rest Home. She undertook a routine visit to the home once every two weeks, and attended at other times and after hours as required.

65. Prior to Dr F seeing Mr A on Day 12, EN E completed the second page of the Admission Form, noting Mr A's weight (66.8kg), pulse (56 beats per minute), blood pressure (150/68mmHg), temperature ("normal") and respiratory rate ("normal").

66. On Day 12, Dr F saw Mr A for the first time. She stated that she noted Mr A's history and asked Mr A and staff if they had any specific concerns, as is her usual practice. Dr F advised HDC:

> "[Mr A] complained of difficulty swallowing. He felt this was a result of an upper [gastrointestinal] scope he had while in hospital. There was nothing about this on the discharge summary so I asked my nurse to chase up the report once I was back in surgery. Once this report was available it transpired the scope had been done in December 2010 and not during his recent admission. It was normal."

67. Dr F stated that she examined Mr A's throat and could see no thrush but his mouth looked dry. She stated that staff were encouraging him to eat and drink and he was having Diasip drinks three times a day. She asked that Mr A be provided with a soft diet.

68. Dr F advised HDC that she did not chart vitamin B_{12} at this visit as Mr A's levels had been raised, and the hospital Discharge Summary said to withhold it. She stated that his levels had been checked on Day 7, but as she did not have the results to hand on Day 12, she intended to review these at her next visit.[13]

69. Dr F explained that she considered decreasing Mr A's frusemide,[14] but decided he should continue on his current dose as he had only recently been in hospital with dehydration and she felt this would have been reviewed while he was there.

70. Dr F signed Mr A's Medicine Chart. Dr F stated that Mr A was booked for a review on Day 21, the date of her next routine visit to Sheaffs Rest Home.

71. EN E wrote in the progress notes that Dr F had seen Mr A and that he was to be offered regular fluids. EN E noted that Mr A's meal size should be reduced to medium, and all meat was to be moulied with gravy. EN E noted that Mr A had refused lunch that day.

72. EN E noted on the Wound Assessment and Treatment Form that Dr F had checked Mr A's leg wound, and had instructed to "leave dry when it becomes moist treat with aquacel. Plaster on left wrist. Shoulder fine".[15]

Day 13–Day 16

73. Entries in the progress notes over the next three days include several references to Mr A's food and fluid intake, and his low mood. On several occasions it was noted that

[13] The result from Day 7 was within the normal range.
[14] Frusemide is indicated for the treatment of oedema associated with congestive heart failure and renal and hepatic disorders, and for the control of hypertension (see: www.medsafe.govt.nz/profs/datasheet/f/Frusidtabinj.htm).
[15] This was noted in EN E's entry the following day.

Mr A had refused food or fluids, or that he had taken a few spoonfuls only. Staff recalled that Mr A was quite adamant about how much food he would accept. They stated that he would have three or four spoonfuls and would then politely refuse anything more. Ms B noted that Mr A was "compis mentis" (sic) and "astute" throughout his time at Sheaffs Rest Home.[16]

74. Mrs A was away on Day 12 and Day 13, and her son and daughter visited Mr A on those days.

75. On Day 13, a caregiver noted that Mr A's family had been in to visit and "were concerned but are [used] to his Depression but [his] son was apparently shocked at his deterioration since he had last seen him …".

76. Mr A's daughter advised HDC that she visited her father on Day 13 and found him to be hot, very down and "very, very pale". She recalls that Mr A told her that he had eaten only a nectarine all day as his mouth was very sore and it hurt his mouth and throat to eat. Mr A's daughter stated: "I left thinking that he didn't look or appear very well at all, but at the time didn't comment to the nurses and now that is something that I regret not doing."

77. Mrs A recalls that when she telephoned her son and daughter on Day 13 they both advised her that they had been very shocked to see their father looking so thin and weak. Mrs A stated that when she visited her husband on Day 14, she was upset at how quickly he had deteriorated from when she last saw him. She said that she cried, and was comforted by a staff member.

78. The caregiver noted that Mrs A had visited her husband, and recorded: "She is thinking of taking him home because he is so low, encouraged her to leave him here tonight and think about it …". On Day 14, EN E noted that Mr A's swallowing appeared easier.

79. On Day 15, Mrs A visited her husband and took him for a drive. The caregiver noted: "[L]ow mood, very depressed. Refused Tea but did drink." Mrs A advised HDC that she bought her husband an ice block when they were on their drive, but that he would not eat it because he said that his throat was too sore.

80. There were no entries in the progress notes for Day 16.

Saturday, Day 17

81. On the evening of Day 17, Mr A was readmitted to the hospital. Mrs A and Ms B have provided differing accounts of events leading up to his admission that day. In particular, Mrs A states that Ms B spoke to her about Mr A possibly needing to go to hospital if his condition did not improve. In contrast, Ms B said she had no contact with Mrs A on this day.

[16] As noted in paragraph 18, Mr A was assessed by a psychogeriatrician as having capacity (ie, he was able to understand the nature and forsee the consequences of decisions regarding his personal care and welfare, and able to communicate those decisions). There is no evidence that this changed during Mr A's stay at Sheaffs Rest Home.

82. Mrs A recalls visiting her husband between about 10am and 1pm on Day 17. Mrs A stated:

> "I went to the Rest Home to pick up my husband to take him up town to get his watch repaired, and found him sitting in the lounge, propped up in his easy chair. He seemed quite lethargic, and when I suggested that he might like to go down to his room before we went up town, a staff nurse went and got a wheelchair for him. I got quite a shock, because I had been to see him and taken him for a drive on the Thursday, he had walked out and back to the car easily. Why did he need a wheelchair 2 days later??? When we got him down to his room, he almost fell out of the chair trying to get onto his bed. He just lay there in a foetal position, and I was very concerned at the deterioration from how he was on Thursday."

83. Mrs A said that she tried to encourage her husband to eat, but he was very weak and would not take anything at all. She stated that his frusemide tablet was on the lunch tray with a glass of water, but that she could not get him to take that either as he kept saying his mouth was sore. Mrs A also notes that she tried to get her husband to open his mouth as she had caught a glimpse of whiteness on his tongue, but "he just seemed to be too weak and tired to even try".

84. Mrs A stated that during her visit, Ms B came in, looked at Mr A, and stated: "If he is not eating by Monday, I think we will send him up to the hospital." Mrs A said she answered that he should really be going there that day, in the hope that Ms B would agree, but that Ms B then went away.

85. Mrs A noted that her husband's tongue was white. She stated:

> "By this time I was quite worried and after a while [a caregiver] came in and I said that I thought that I should take him up to hospital myself. She went away to find [Ms B], but never returned, so I left and went home to ring [my daughter], to get her to come over urgently."

86. At 1.30pm, the caregiver had recorded in the progress notes:

> "Has hardly eaten anything so far today 1 tspn of weetbix @ b/fast, 100 mls diasip for morning tea. [Mrs A] tried to feed him @ lunchtime, but he wouldn't eat, just wants to lie down all the time. Started a fluid balance chart today."

87. Ms B, who lives on the premises, stated that she had no contact with Mrs A on Day 17. Ms B recalls that at around 2pm, she spoke with the caregiver who reported that Mr A was refusing to eat or drink. Ms B stated in her response to the provisional opinion that it was not mentioned to her at that time that Mrs A wanted to see her or that Mrs A was thinking of taking Mr A to hospital. Ms B requested that a food and fluid chart be started. She stated that she then went to do some shopping, and that while she was out she bought a bottle of water so that they could better measure Mr A's intake. Ms B stated that on her return, she was called over to the home by a caregiver. Ms B said that she observed a conversation between Ms C and her father about going to hospital, and then went to telephone for an ambulance and prepare the

necessary documents. Ms B noted in Mr A's progress notes: "Daughter arrived and requested that he go to hospital 7:30pm."

88. I acknowledge the conflicting evidence from Mrs A and Ms B in relation to their contact on this date. However, my concerns about the response to Mr A's deteriorating condition, as outlined in the opinion section of this report, stand irrespective of whether Mrs A and Ms B spoke with one another. Accordingly, I have not attempted to reconcile these accounts.

89. Ms C recalls that she arrived at Sheaffs Rest Home at about 6pm, and was shocked at how frail and emaciated her father looked. She stated that he was only able to take water from a syringe, and could take only three steps before he became breathless and had to sit down. Ms C stated that her husband found a caregiver, who then contacted Ms B, and arrangements were made for Mr A's transfer to hospital.

90. Ms B advised HDC that had Mrs A expressed a wish for Mr A to go into hospital on that day or any other day she would have arranged for him to be admitted to hospital, and that she did this when requested by Ms C.

91. According to the fluid balance chart,[17] Mr A had a total of 300mls of Diasip and 50mls of water between 10am and 4pm. Records from the ambulance service show that the ambulance arrived at Sheaffs Rest Home at 7.01pm. The ambulance officer recorded that Mr A was alert and orientated but weak and frail, and noted: "Low Nutrition & Fluid intake last 7 days."

Subsequent events

92. Mr A was taken to the hospital and assessed in ED. The triage nurse noted that Mr A was "frail — dry tongue looks like thrush". His weight was recorded as 57.8kgs. Mr A was assessed by a doctor and started on fluids. An ECG was also performed. He was found to be dehydrated and to have had a myocardial infarction (heart attack).

93. In consultation with the family, it was decided that Mr A's condition should be treated conservatively. It was noted that during his previous admission, Mr A had signed a document consenting to full medical management but not active resuscitation.

94. Mr A's condition continued to deteriorate, and he died in the hospital a few days later.

Additional information

95. RN D stated that had she been informed that Mr A was refusing to eat, she would have evaluated the care plan and amended this where necessary. She stated that at no time was it mentioned in the progress notes or to her verbally, that Mr A or his family had complained to staff about his having a sore mouth and throat.

96. RN D also stated that she was not alerted to concerns about Mr A's oral intake at any time. When asked whether she was happy with the way his intake was monitored by staff, given the instructions outlined in his care plan, RN D stated: "Not really.

[17] The Fluid Balance Chart did not include Mr A's NHI number or Date of Birth unique identifier.

However in saying that, on talking to the girls, it wasn't that he wasn't taking it. He would just take so much and then politely refuse to take it…" RN D noted that the day the fluid chart was started was the day Mr A refused to eat anything. She noted that if staff had followed the care plan, they would have weighed him weekly. She commented that staff could possibly have started a food/fluid chart a little earlier.

97. Several staff involved in Mr A's care were asked about the means by which they are informed of the care needs for a new resident, and of any changes in a resident's condition. The verbal handover at the start of each shift was identified as particularly important in this respect. The caregivers spoken to by HDC stated that it was their usual practice to read the care plans for new residents. Ms B stated that caregivers definitely read the initial notes but she was "not sure that they use the care plans as often as they should". She stated further that she did not, however, think this reflected on the care.

Changes made

98. Ms B and RN D advised HDC of the following changes at Sheaffs Rest Home since and/or in response to these events:

- a new wound progress form has been introduced, which requires a sketch of the wound at each dressing;
- Sheaffs Rest Home has joined an online education and resource programme;
- policies and procedures have been upgraded;
- the Medicines Care Guides for Aged Residential Care (2011) are now being used;
- a Shekel Health Chair Scale has been purchased for better weight recording, and the names of residents requiring weekly weighs are recorded on a whiteboard;
- there has been further staff education on hygiene and personal care, including feeding;
- a new nutrition and hydration assessment tool is being used;
- a one-page "Care Plan Assessment" form has been introduced for caregivers to complete during the first week of a new resident's admission, to help evaluate how a care plan is working;
- caregivers are now required to write in the notes at least once every 24 hours for the first week after a new resident is admitted; and
- residents are admitted only when the EN or RN is on duty.

99. RN D also noted that following these events, she:

- has undertaken to review initial care plans with the resident, resident's family and staff one week after the resident's admission, rather that waiting until the third week;
- documents every interaction she has with residents and their families, no matter how small that interaction or conversation is;
- reads all clinical notes before starting the jobs she has for that duty to ensure staff have not forgotten to verbally hand over something of importance;

- draws caregivers' attention to any matters that have not been correctly documented;
- reads through the wound care folder at the start of each duty; and
- completes the wound assessment and treatment form with caregivers and countersigns this, when supervising them doing dressings.

100. In response to my provisional opinion, RN D also noted that she has introduced a new medication reconciliation form at Sheaffs Rest Home, and GPs now visit all new residents within 48 hours of admission, which ensures that medication charts get signed.

Responses to provisional opinion

RN D

101. In addition to the comments incorporated above, RN D made the following comments in response to the provisional opinion.

102. RN D stated that she assessed Mr A's wound on Day 5 and gave instructions to the caregiver on which dressings to use. She noted that the dressing material used was noted on the wound care chart, and that the organisational policy allowed care staff to do wound dressings.

103. RN D also stated:

> "I acknowledge that I should have been more proactive in seeking [Mrs A's] input into the care plan once she returned [home]. I believed that I would get the chance to see her in the near future as there is a lot of informal interaction with the residents and their families at the home. I am very sorry that I pre-emptively recorded that [Mrs A] had input into the development of [Mr A's] care plan. I agree with Ms Baker's comments that it was inappropriate to do so and could have jeopardized the integrity of the record. [The EN] who does the admissions when I am not at work, now makes an appointment time for me to meet with the family. This ensures that the assessment is more formal and correctly documented.
>
> …
>
> I accept Ms Baker's and Ms Meijer's comments that a nursing assessment should have been completed with the Care plan and that base line recordings should have been recorded. I utilized the observation recorded on the Transfer form from the hospital. I had no need to review the admission form … Since this incident I review all base line recordings taken and counter sign them to ensure they are documented correctly …
>
> I believe that I fulfilled my obligations by providing guidance to the care giving staff at the rest home through the care plans provided. I provided appropriate care plans to follow that reflected [Mr A's] needs at the time they were developed and the delay in having the nursing assessment done did not change this …

> This incident has allowed me to reflect upon my nursing practice and make improvements to my practice and implement changes within the rest home. The new 'Care Plan Assessment form' had been very beneficial in assisting me to evaluate what is needed in the care plan as well as how the care plan is working. Writing in the notes for the first week after the resident has been admitted has also improved resident care and care planning.
>
> Making a formal appointment with family members to complete the nursing assessment and then having a review of how they are finding things a week later has worked extremely well and has allowed for any concerns etc to be sorted out quickly and effectively. It has also allowed for more communication to occur.
>
> … I now read all residents notes before starting other tasks, have started computerizing residents care plans, document every interaction with residents and families, and draw caregivers attention to any matters not documented correctly."

104. RN D also noted that during Sheaffs Rest Home's June 2013 certification audit Sheaffs Rest Home achieved full attainment in care planning, assessment, wound care, and medication.

Ms B and Ellora Enterprises Ltd

105. In addition to the comments incorporated above, Ms B and Ellora Enterprises Ltd made the following comments in response to the provisional opinion.

106. Ms B stated that staff followed instructions regarding Mr A's diet and tried hard to encourage him to eat. She stated that Mr A was given a soft diet, was offered his dessert before his main meal, and was offered his meal away from the dining room. Mrs A also assisted with meals on occasion.

107. With regard to medication management, Ms B stated that Sheaffs Rest Home staff will no longer ask new residents entering Sheaffs Rest Home from the hospital whether they would like to change their GP to Sheaffs Rest Home's contracted GP. Ms B stated that doing this will ensure that medication changed at the hospital will be signed by the resident's existing GP, and that the current GP is familiar with the hospital admission and any follow-up actions. She stated: "Changing doctors can then take the normal process and ensures that the new doctor can obtain the relevant information." She also stated that an appointment is now booked with a new resident's GP within 48 hours, regardless of where they have been admitted from.

108. Ms B stated that Mr A's wound care was satisfactory. With regard to documentation, she stated that in a rest home setting it is not required that progress notes are documented each shift or daily. She noted: "The caregivers have documented any point of interest or anything out of the ordinary on days they were working." She stated further:

> "All entries in the progress notes have been dated, the writing is legible and they have been signed with designation. I note only one entry that does not have a

designation next to it and that was on [Day 9]. Sheaffs Rest Home uses a verifiable specimen list that allows us to verify staff signatures or initials."

109. Ms B advised that during Sheaffs Rest Home's June 2013 certification audit, Sheaffs Rest Home received excellent findings and feedback from the auditors.[18] She also stated: "The residents and family members interviewed were also very positive and full of praise for the home."

Other relevant standards

110. The Ministry of Health Guide "Safe Management of Medicines" (1997) states:

"**Ordering and Receiving Medicines**

a) Medicines must be authorised in writing on the Resident Medication Profile and signed by the resident's medical practitioner.

In an emergency the doctor can give telephone instructions. Enter these on the Resident Medication Profile and get them signed by the doctor as soon as possible on the next visit."[19]

Opinion: Introduction

111. When Mr A was admitted to Sheaffs Rest Home his risks in relation to poor food and fluid intake and low mood were clearly identified. Mr A's deterioration over the 16 days that followed was not managed promptly or decisively by Sheaffs Rest Home staff, or in accordance with his care plan. It is concerning that it was not until Day 17 that action was finally taken to respond to Mr A's deteriorating condition. Even more concerning is that it was only at the instigation of Mr A's family that medical intervention was sought. This was clearly inappropriate and inadequate care.

112. Mr A did not receive reasonable care at Sheaffs Rest Home. In my opinion, Mr A's care fell below expected standards in a number of respects, and was the result of both individual and organisational failings, as outlined below.

[18] A copy of the draft audit report was provided to HDC.

[19] In May 2011, the Ministry of Health issued the "Medicines Care Guides for Residential Aged Care". This states: "Medicines reconciliation should be performed by health practitioners such as general practitioners, nurse practitioners, other authorised/designated prescribers, pharmacists or registered nurses."

Opinion: Breach — RN D

113. Registered nurse RN D's role was to fulfil the obligations of the rest home under the Age Related Residential Care Services Agreement. She was required to assess residents on admission, when their level of dependency changed, and at each six-month review date. She was also required to develop and review care plans in consultation with the resident and family/whānau, to advise on care and medication administration, to provide and supervise care, to act as a resource and provide education, to monitor the competence of other nursing and care staff to ensure safe practice, to advise management of staff training needs, and to assist in the development of policies and procedures.

114. Mr A was admitted to Sheaffs Rest Home. On his admission, Sheaffs Rest Home was provided with a copy of Mr A's discharge summary from the hospital, an Inter-Hospital Transfer form, and a prescription form. Sheaffs Rest Home Manager, Ms B, and EN E, also obtained information about Mr A from conversations with Mrs A and Ms G, prior to Mr A's admission, although the nature of that information is not clear.

115. Sheaffs Rest Home policy required three key documents to be completed on a resident's admission to the rest home: an Admission Form, a nursing assessment, and an initial care plan.

116. On Mr A's admission to Sheaffs Rest Home, RN D assumed responsibility for completing the nursing assessment and Mr A's initial care plan. RN D was also responsible for Mr A's medication management. Ms B assumed responsibility for completing the Admission Form (see below).

Nurse assessment and care plan

117. Sheaffs Rest Home policy required the nurse assessment to be completed together with the resident and resident's relative or agent. The policy also required the nurse assessment and care plan to utilise information obtained from the resident, resident's representative, the referring agency and/or previous care provider, along with client observations and examinations. Sheaffs Rest Home policy also noted that the nurse assessment was "the most important foundation on which to build a good plan".

118. RN D said that on the day of his admission she met with Mr A and asked him some general questions, and then completed the assessments and care plan. RN D was unable to meet with Mrs A that day. RN D said that she completed the assessment and care plan by drawing on information she obtained from her conversation with Mr A, Mr A's Discharge Summary and Inter-Hospital Transfer form, and information she obtained from an informal conversation earlier that day with staff at the hospital and an earlier conversation with Ms B and EN E.

119. RN D did not complete the nursing assessment because she wanted to speak with Mrs A first. RN D advised HDC that she had intended to "catch-up with [Mr and Mrs A] to complete the assessment"; however, because Mrs A was away, RN D intended to

complete the assessment with input from Mrs A on Day 18, following RN D's return from leave.

120. It is not clear on what basis RN D formed the view that Mrs A was away. I am critical that RN D was not more proactive in contacting Mrs A to arrange a time to meet with her to seek her input into the nurse assessment. Mrs A was at the rest home on Day 7, when she picked up her husband and took him to an appointment at the hospital, and accordingly could have been available to meet with RN D before RN D went on leave on Day 12. However, there is no evidence that RN D made any effort to meet with — or even talk with — Mrs A before going on leave.

121. RN D completed a detailed, nine-page care plan, which identified a number of issues including a high risk of skin breakdown, high falls risk, poor diet and food intake with weight loss, and depression. In the care plan, RN D listed a number of interventions for those risk factors, including interventions for risks associated with Mr A's diet, food intake and weight loss. RN D also requested that Mr A's sinus on his right shin be monitored. RN D completed a Barthel Index, a falls risk assessment, a continence assessment, and an assessment of pressure area risk. RN D wrote on the care plan that it had been completed with input from Mrs A.

122. My expert nursing advisor, registered nurse Ms Sylvia Meijer, advised me that a care plan is based on a registered nurse assessment, and the care plan should reflect that assessment. Ms Meijer was initially critical of RN D's care planning process, because the nursing assessment was not completed and appeared fragmented, and, accordingly, it was not clear what assessments the care plan was based upon. Ms Meijer was also critical of the care plan having been completed without input from Mr A's family, despite the plan indicating that such input had been received.

123. On review of further information supplied by RN D, including RN D's explanation (as set out above) as to why the nurse assessment was not completed, Ms Meijer remained critical that there was no initial Sheaffs Rest Home assessment or baseline recordings documentation to show the basis for the initial care plan. However, Ms Meijer advised that "this care plan reflects the resident's care needs and guides care staff to provide appropriate care", and that the rationale for the care plan was reasonable.

124. I accept Ms Meijer's advice that the care plan was appropriate. However, I remain concerned at RN D's process in developing the care plan. Sheaffs Rest Home policy and my advisor both identify that the care plan should reflect information contained in the nursing assessment, and that the assessment is the foundation on which to build a good plan. I find it unusual that RN D considered it reasonable to delay completing the nursing assessment for 17 days until she could obtain input from Mrs A, and yet also considered it reasonable to complete a full and detailed nine-page care plan based on an incomplete nursing assessment. I am also concerned that RN D indicated on the care plan that it had been developed with input from Mr A's wife when it had not. Although I acknowledge that it was RN D's intention to discuss the care plan with Mrs A on return from leave on Day 18, it was inappropriate for her to preemptively record that she had done so. In doing so, RN D jeopardised the integrity of the record.

As noted above, I also do not consider that it was necessary for RN D to wait until Day 18 to obtain Mrs A's input into the nursing assessment and care plan, as Mrs A appears to have been available before RN D went on leave on Day 12.

125. I accept Ms Meijer's advice that while Mr A's care plan was appropriate, RN D's care planning fell below accepted standards, and for this I find that RN D breached Right 4(1) of the Code.

126. In my view, RN D should reflect on my advisor's comments about the importance of clearly documenting baseline recordings during the admission assessment and care plan process.

Medication management

127. Sheaffs Rest Home's "Medicines Safety Management Protocol" set out the steps required to ensure appropriate medication reconciliation, which included ensuring that prescribed medication for a client was documented on that resident's medication administration chart and signed by a GP to authorise the documented medicines.

128. Mr A's Medicine Chart was commenced on Day 1, but was not viewed and signed by Mr A's GP until Day 12. Ms B advised HDC that on Day 2 she checked off Mr A's medications with the medication sheet she received with Mr A's medication from the pharmacy. However, she decided to wait until Mr A's next doctor's appointment to have the medication sheets signed. RN D advised that she was not aware that Ms B had chosen to dispense the medication from the unsigned medication chart and she did not have reason to check it in the following days.

129. Ms Meijer advised me:

> "It is not best practice to administer from a chart not signed by a GP. Medicines must be authorised and signed by the Resident's medical practitioner according to the Ministry of Health 'Safe Medicine Guide' (1997)."

130. The Ministry of Health guide "Safe Management of Medicines" (1997) states: "Medicines must be authorised in writing on the Resident Medication Profile and signed by the resident's general practitioner."

131. Mr A's medication management was not aligned to best practice because, as noted by Ms Meijer, "there was no clear indication that medication reconciliation occurred and there was a 10-day delay in the GP signing the medications on the chart". It is a risk to residents for staff to administer unsigned medication, and I am guided by Ms Meijer's opinion that there was a moderate departure from the expected standard of care in respect of Mr A's medication management.

132. As the registered nurse for Sheaffs Rest Home, RN D was responsible for residents' medication management. In addition, RN D was responsible for providing and supervising care, and monitoring the competence of other nursing and care staff to ensure safe practice. There is no indication that Mr A's medication was administered

incorrectly. However, my advisor states that medication can be administered only when signed by a GP or nurse practitioner, and registered nurses or competent care staff are required to check that medication is signed on the medication chart each time medication is administered to a resident. That did not happen in Mr A's case, and I accept Ms Meijer's advice that management of Mr A's medication was not aligned to best practice, and this was a moderate departure from expected standards. Given RN D's responsibilities for medication management at Sheaffs Rest Home, I find that she must accept responsibility for this failing. Accordingly, I find that RN D breached Right 4(1) of the Code for failing to ensure that Mr A's medication was appropriately managed and reconciled on his admission to Sheaffs Rest Home.

Opinion: Breach — Ms B

133. Ms B's responsibilities as Facility Manager, as set out in her job description, included ensuring all statutory and contractual obligations were met, ensuring all clinical and non-clinical services at Sheaffs Rest Home were delivered to clients in a safe and dignified way, managing and maintaining supervision of clinical and non-clinical services, and ensuring services were acceptable to each client. As Facility Manager, Ms B had overall responsibility for ensuring a quality service was provided.

134. There are a number of areas in which the care provided to Mr A at Sheaffs Rest Home was below the expected standard, and for which Ms B, as Facility Manager, must accept responsibility. As further discussed below, those areas included staff compliance with Mr A's care plan, the management of Mr A's medication, and the failure of staff to appropriately seek registered nurse or general practitioner review of Mr A when his health deteriorated.

135. Given the variance in accounts between Mr A's family and staff at Sheaffs Rest Home, and the lack of clear documentation, I have not made a finding on whether Mr A complained to staff of a sore and dry mouth and/or throat and, if he did so, whether staff adequately responded to that information. If Mr A did provide that information, a failure by staff to respond appropriately would warrant criticism.

Response to deteriorating condition

136. Mr A's care plan identified that he was at risk owing to poor diet and food intake. To manage that risk, his care plan identified a number of interventions, including encouraging Mr A to feed himself, weekly weighs, reporting changes in Mr A's appetite, providing him with food he enjoyed, and ensuring that he had at least six glasses of fluid a day, three meals, morning and afternoon tea and supper, and Diasip. The care plan also instructed staff to start a food chart should Mr A's appetite decrease.

137. It is frequently recorded in the notes between Day 13 and Day 16 that Mr A had refused food or fluids, or that he had taken only a few spoonfuls of food. It is also

recorded that Mr A's mood was low over this period. Staff were aware of Mr A's decreased food and fluid intake, as demonstrated by the records made in his progress notes. I note Ms B's submission in response to the provisional opinion that staff tried hard to encourage Mr A to eat. However, staff did not initiate interventions as set out in his care plan. There is no evidence that the changes in Mr A's appetite were reported to the manager, that a food chart was commenced, or that a weekly weigh was undertaken.[20]

138. In addition, I am critical that the notes do not provide a clear indication of Mr A's exact food and fluid intake. Ms Meijer advised me that "[i]t is accepted practice that a food/fluid chart is commenced for monitoring purposes, and [registered nurse]/[general practitioner]/dietician input is sought if a resident's intake is poor". In Mr A's case, despite indications from Day 13 of decreased intake, a food and fluid chart was not started until Day 17. This was poor care.

139. The management of Mr A's nutrition and hydration intake was not consistently monitored. Mr A's care plan recommended that nutrition intake be monitored if Mr A's intake decreased. It is not clear whether the failure to follow Mr A's care plan when he began refusing food and fluids was because of staff failures to read and be familiar with the care plan, or whether the care plan was read but not followed. In any event, as Facility Manager, it was Ms B's responsibility to ensure that care plans were adequately communicated to caregiving staff, and that care plans were being complied with. Ms B must accept responsibility for staff failures to follow the care plan in this case.

140. Ms Meijer informed me that when a resident's health deteriorates, including reduced nutritional intake or dehydration, it would be common practice to seek input from a registered nurse or general practitioner.

141. On Day 12, EN E requested GP Dr F to review Mr A. EN E was aware that Mr A had yet to be seen by a GP, and also found that Mr A was not eating well and seemed depressed. In my view, a medical review should have been sought sooner.

142. Following Dr F's review, EN E recorded in Mr A's progress notes that Mr A was to be offered regular fluids, his meal size should be reduced, and all meat was to be moulied with gravy. It is unclear whether these instructions were followed.

143. Given Mr A's deterioration after Dr F's review on Day 12, in particular his reduced food and fluid intake, further medical or nursing input should have been sought. As noted by Ms Meijer, Mr A required "astute monitoring and regular Registered Nurse evaluation and input", because of his general frailty. That did not happen in this case. I note that RN D was on leave from Day 11 to Day 17, but staff should have contacted the doctor, doctor's nurses, or the hospital for input on Mr A's care needs in response to his deterioration, and for a review of his care plan.

[20] It appears that the only time that Mr A was weighed during his 16-day stay at Sheaffs Rest Home was on Day 12, when EN E recorded his weight on the second page of the Admission Form as being 66.8kgs.

144. Mr A's family have described their concern at Mr A's deterioration over the short time he was at Sheaffs Rest Home. Mrs A stated that she got "quite a shock" on Day 17, and that she was very concerned at the deterioration in her husband's condition in the two days since she had taken him for a drive. Mr A's daughter also stated that she was shocked at how frail and emaciated her father was when she visited him on the evening of Day 17.

145. It is not acceptable that staff failed to respond to Mr A's poor food and fluid intake until Day 17, when a food and fluid chart was commenced and when, at the request of the family, further medical input was sought. In my view, Ms B needed to respond more quickly, and do more to satisfy herself that the facility for which she was responsible, and its staff, were providing Mr A with quality care.[21] In my opinion, Ms B breached Right 4(1) of the Code for failing to do so in this case.

Medication management

146. As noted above, Sheaffs Rest Home's "Medicines Safety Management Protocol" set out the steps required to ensure appropriate medication reconciliation, which included ensuring that prescribed medication for a client is documented on that client's medication administration chart and signed by a GP to authorise the documented medicines.

147. Mr A's Medicine Chart was commenced on Day 1, but was not viewed and signed by Mr A's GP until Day 12. Ms B advised HDC that on Day 2, she reconciled the medication when it arrived, in that she checked off Mr A's medications with the medication sheet she received with Mr A's medication from the pharmacy. However, she decided to wait until Mr A's next doctor's appointment to have the medication sheets signed.

148. Ms B deliberately chose to wait until Mr A's next doctor's appointment to have Mr A's Medicine Chart signed. As Facility Manager, she should have known that this was unacceptable. The decision to delay the signing of Mr A's medication sheet was contrary to Sheaffs Rest Home policy, and was contrary to the Ministry of Health guide "Safe Management of Medicines" (1997). Administering unsigned medication is a risk to residents and staff. While there is no evidence that Mr A's medication was administered incorrectly during his time at Sheaffs Rest Home, Ms B erred in her judgement to wait to have the GP authorise Mr A's Medicine Chart, and placed Mr A at risk by doing so. She also failed to comply with Sheaffs Rest Home's policy, and Ministry of Health guidelines.

149. I find that Ms B breached Right 4(1) of the Code for failing to ensure that Mr A's Medicine Chart was checked and signed by the GP in a timely manner.

[21] The responsibilities of facility managers to satisfy themselves that the facilities for which they are responsible, and their staff, are providing quality care is also discussed in Opinion 08HDC17105 (available on the HDC website: www.hdc.org.nz).

Opinion: Breach — Ellora Enterprises Ltd trading as Sheaffs Rest Home

Care and treatment

150. When Mr A was admitted to Sheaffs Rest Home, the risks associated with his food and fluid intake were identified. Nevertheless, staff did not manage those risks effectively. Mr A's care plan was not complied with, and a review by a doctor or registered nurse was not requested when Mr A deteriorated. Staff failed to comply with policies for medication management and nurse assessment and care planning. Mr A did not receive the care to which he was entitled.

151. While I have identified my concerns about the decision-making and actions of key individual staff, Sheaffs Rest Home also had a responsibility to operate the rest home in a manner that provided Mr A with services of an appropriate standard. That responsibility comes from the organisational duty on rest home owners to provide a safe healthcare environment for residents. This duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It also includes responsibility for the actions of its staff.

152. As identified above, there were some inadequacies in Mr A's admission, nursing assessment and care planning process. In particular, the nursing assessment was not completed, and input into the care plan was not sought from Mr A's family, as required by Sheaffs Rest Home policy. In addition, contrary to policy and Ministry of Health guidelines, Mr A's medication administration chart was not signed by the GP. Staff failed to comply with the care plan, did not implement care as instructed when Mr A's condition deteriorated, and did not adequately monitor his nutrition and fluid intake. Finally, staff did not seek timely review of Mr A by a doctor or registered nurse when his condition deteriorated.

153. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and assist staff to do what is required of them.[22] As this Office has also previously stated, without staff compliance, policies become meaningless.[23]

154. Sheaffs Rest Home had a responsibility to ensure that staff complied with policies and provided services of an appropriate standard. Sheaffs Rest Home failed to do so, and breached Right 4(1) of the Code.

Documentation

155. I note Ms B's response to the provisional opinion regarding the accuracy in the dating and signing of the progress notes, and that it is not required that progress notes are documented in each shift or daily in the rest home environment. However, I remain concerned about the standard of documentation at Sheaffs Rest Home. For example: admission assessment forms were not completed; the care plan marked that it had

[22] Opinion 07HDC16959 (20 May 2008) and Opinion 10HDC00308 (29 June 2012).
[23] Opinion 09HDC01974 (21 June 2012).

been made with input from Mr A's family when it had not, which jeopardised the integrity of the record; wound care documentation was incomplete; some information on the admission form was too general; and the Fluid Balance Chart had a name only, with no NHI or Date of Birth unique identifier.

156. Furthermore, I note my expert's comments that documentation was not completed in a consistent manner, which has the potential to lead to fragmented care provision and delays in recognising a resident's deteriorating condition. With information recorded in resident notes, handover notes, the communication book, and whiteboard, there is potential for further fragmentation. Poor quality information and recording will affect the ability of staff to provide continuous and appropriate care.

157. The importance of good record-keeping cannot be overstated. Accurate documentation is the basis for delivering continuous and appropriate care. In the case of Mr A, who was vulnerable to deterioration owing to his low mood and food and fluid intake, accurate and comprehensive records were important to allow a comparison of his condition over time, for more prompt identification of his deterioration.

158. In my view, Sheaffs Rest Home documentation was suboptimal, and I find that Sheaffs Rest Home therefore breached Right 4(2) of the Code.

Recommendations

159. In response to the provisional opinion, RN D and Ms B provided apologies for Mrs A, which have been forwarded to her.

160. I recommend that Sheaffs Rest Home:

- review its documentation policies, and its policies in relation to communicating with family during a resident's admission;
- conduct an audit on the effectiveness of the new nutrition and hydration assessment tool and the "Care Plan Assessment" form implemented since these events, and conduct an audit of progress notes to ensure entries are being made at least once every 24 hours, as now required by Sheaffs Rest Home policy;
- provide HDC with evidence of a formal process for making sure that caregivers are aware of, and comply with, resident care plans; and
- provide HDC with an update on these matters by **27 August 2013**.

Follow-up actions

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Sheaffs Rest Home (Ellora Enterprises Ltd), will be sent to the Nursing Council of New Zealand and it will be advised of RN D's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Sheaffs Rest Home (Ellora Enterprises Ltd), will be sent to the Ministry of Health, the Bay of Plenty District Health Board, and the New Zealand Aged Care Association.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Sheaffs Rest Home (Ellora Enterprises Ltd), will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following preliminary expert advice was obtained from registered nurse Sylvia Meijer:

"**Health and Disability Commissioner** **20 December 2011**

Thank you for the opportunity to provide expert advice on the care provided to [Mr A] at Sheaffs Rest Home, HDC reference 11/00423. I have been asked to provide an opinion to the Commissioner and I have read and agree to follow Commissioner's guidelines for Independent Advisors. I do not have a conflict of interest with the parties involved.

This report will begin with an overview of my professional qualifications and clinical experience, followed by an outline of events and my professional opinion on each posed question. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, reviewing the relevant literature and my own professional clinical experience of working with older adults.

Personal and professional profile
Nurse Practitioner Older Adult, with prescribing rights; NCNZ APC 112474

I am a Registered Nurse, with a Masters Degree (MPhil.Nursing), 2 Postgraduate Diplomas in Nursing and Health of Older People, a Postgraduate Certificate in nursing, in addition to a Diploma in Management. My Masters research related to assessment of older people in care facilities. I have been nursing for 33 years and am currently employed by the Central Primary Health Organisation in Levin as a Nurse Practitioner, working across 3 care facilities and general community. As a Nurse Practitioner I work alongside care staff, registered nurses and managers. My clinical work includes assessments, planning, implementing interventions and evaluating care. Staff education, Quality assurance, research and strategic planning are also components of my daily work. Prior to January 2011, I was the Clinical Services Manager of a care facility for 9 years, with responsibilities for clinical oversight, resident care, staff management, education and strategic planning. My clinical experience includes working with people with multiple co-morbidities and chronic conditions, palliative care, district nursing, surgical and medical nursing, ICU, ED and after-hours hospital co-ordinator. Professional involvement includes national facilitator of the Older Person's Nursing Network for the College of Nurses Aotearoa, Memberships of the College of Nurses, New Zealand Nurses Organisation and New Zealand Association of Gerontology. I am involved in National, Regional and community health projects. Conference presentations include national and international presentation on improving care for older people and appropriate health care delivery.

Outline of events

- [Mr A] was admitted to Sheaffs Rest Home on [Day 1], from the hospital. The Needs Assessment and Service Coordination (NASC) agency assessed [Mr A] as requiring rest home level care on [date during hospital stay].

- Medical diagnosis included multiple co-morbidities, such as Diabetes type 2, Congestive heart failure, Aortic stenosis, Depression, Chronic ulcer right leg (osteomyelitis), Diverticulitis.

- [Mr A's] health became progressively frailer while at the rest home.

- During admission at Sheaffs Rest Home, [Mr A] complained of a sore throat and mouth.

- [Mr A] was noted to be low in mood and increasingly reluctant to eat and drink.

- [Mr A] was reviewed by the GP on [Day 12].

- On admission, weight was recorded as 68 kg, weight on admission to the hospital on [Day 17] was recorded as 57.8 kg.

- [Mr A] was re-admitted to [the hospital] on the [Day 17]. The medical officer's impression on admission was noted as 'clinically dehydrated and malnourished, inferolateral myocardial infarction with acute and chronic kidney injury'.

The referral instructions to me from the Commissioner's office were to comment on:

- Concerns about the care provided by Sheaffs Rest Home
- Monitoring and management of nutrition and hydration
- Medication management
- Whether medical intervention was sought appropriately
- Care planning and implementation (including planning for end of life care)
- Documentation

Concerns about the care provided by Sheaffs Rest Home

The documentation provided indicated that [Mr A] was in frail health and with the knowledge of hindsight may have benefited from hospital level care and more continuous Registered Nursing assessment and care planning. However, [Mr A] was assessed as requiring rest home level care and the family and health care staff agreed on placement in Sheaffs Rest Home. Rest homes have access to Registered Nurses and GPs for advice and guidance and have policies to assist staff to recognize when a resident's condition deteriorates and how to call for further advice. Explicit documentation in notes and care plan should guide staff to detect any deterioration. The documentation of [Mr A's] care is fragmented and not consistently completed. This may have hindered the continuity of care and delayed

action to seek further advice or care. For instance: the wound care documentation was not completed, the size and type of wound was prompted but not completed on the form. The first entry on the wound assessment and treatment form is on [Day 5]. Although daily dressings were ordered, the dressings were not changed on [Day 7, Day 12, and Day 15]. The treatment form indicated that a caregiver signed the initial treatment. The documents provided do not indicate if this caregiver received education on wound care. Wound care is generally considered to be in the competency sphere for Registered Nurses, as an element of assessment is required to determine the type of wound dressing. In a setting where no Registered Nurse is continuously available, this is at times delegated to an Enrolled Nurse, however, both caregivers and Enrolled Nurses work under the supervision of a Registered Nurse. The dressing instructions are not obvious; there is no evaluation of the wound on the treatment form and no indication of what dressing material is used. There is no apparent wound assessment or an indication that Registered Nurse assessment was undertaken. In many parts of New Zealand the District Nurses or the Wound Care nurses of the public hospital have input in the management of wounds. There is no evidence that the wound was dressed during the first three days of admission. [Mrs A] mentioned that [Ms B] had seen [Mr A] while [Mrs A] was visiting on [Day 17] and stated 'if he is not eating by Monday, I think we will send him up to the hospital'. There is no indication that Registered Nurse or GP advice was sought at the time, as would be common practice in situations where residents show a decline in health status. I am unable to determine from the documents provided if [Ms B] is qualified to assess resident's health decline or if further advice was sought. [Ms B's] telephone response to the Commissioner's Office on the 16th of November 2011 indicated that she had not spoken to [Mrs A] and had only come into the facility later that day when … called regarding [Ms C's] request for her father to go to hospital. There appears to be a discrepancy between the recollections of events as recalled by [Mrs A] and as recalled by [Ms B]. It is not evident in the notes that regular family and staff communication took place once [Mr A's] condition deteriorated. It appears that expectations and concerns about care and care provision were not discussed. [Mrs A] noted that she did not speak to a Registered Nurse. [Ms B] noted in her 30 May 2011 reply, she was unaware that the family wanted [Mr A] re-admitted to hospital. According to [Ms B's] letter on the 17th of November 2011, Registered Nurse [RN D] had worked a day duty at the public hospital on [Day 1] followed by an afternoon duty at Sheaffs Rest Home the same day. This indicates that the Registered Nurse worked more than an 8 hour duty that day. Although double or extended duties are at times unavoidable, it is not considered best practice and there is fatigue associated with extended shift hour work (NZNO 2010), which can lead to reduced attention to details. It is essential that deterioration of condition and reduced nutrition and hydration are recognized in a timely manner to ensure appropriate action. At times, when residents become increasingly frailer, no remedial treatment would reverse the health concerns. This does not negate the need to identify any deterioration of a resident's condition. If frailty becomes irreversible, there would generally be a discussion with the family and palliative care may be suggested.

The care provided to [Mr A] during his stay at Sheaffs Rest Home is in my opinion a moderate departure from expected standard of practice.

Monitoring and management of nutrition and hydration

The progress notes provide an indication that [Mr A] required assistance with meals and that at times he refused food. As the progress notes were not completed each duty or each day, it is difficult to determine what the exact food and fluid intake was. Throughout the progress notes, there is an indication that [Mr A's] appetite was poor. It was also noted in the Needs Assessment and Service Co-ordination (NASC) assessment by [Ms G], that the family observed that [Mr A] had lost weight when they visited at Christmas time and poor intake of food and fluid was noted during this assessment. The NASC assessment was dated as generated on [Day 7], and faxed to Sheaffs Rest Home on [Day 8] at 15.20 hours. [Ms B] noted in the 30th of May 2011 reply that the NASC assessment stated that [Mr A] had a lack of interest in food and fluid intake. As this report was faxed to Sheaffs Rest Home on [Day 8] it appears that this information was not available on admission and any declining interest in food and fluid intake or decline in general health should give reason for further assessment and monitoring. Food and fluid intake monitoring is identified in the care plan. For instance, food intake and Blood Sugar Levels (BSL) are closely linked. Blood sugar levels were first recorded on a blood sugar and insulin form on [Day 5], 3 days after admission to the facility. For residents with diabetes, a baseline BSL on admission would be usual practice. The care plan states to take BSLs on Mondays, three times a day. The times recorded on the BSL chart were at 7.30 AM, 11.30 AM and 4.30 PM. For Type 2 Diabetes, it is considered Best Practice in New Zealand to test BSL 4 times daily on testing days, at pre-breakfast (fasting), 2hrs after breakfast, 2hrs after lunch and 2hrs after dinner (Diabetes info NZ, 2010, NZ Guidelines on Management of Type 2 Diabetes, 2003). Sheaffs Rest Home Diabetes protocol and policy may indicate a rationale for different testing times, however the policy was not available with the Commissioner's Office documents and I am therefore unable to comment if staff adhered to their policies or the rationale for different testing times. The progress notes on [Day 12] noted that [Mr A] had refused food. There is no indication this was notified to the RN or if after continued poor appetite Dietitian input was sought. The fluid balance chart was not commenced when food intake concerns first occurred on [Day 8], although the care plan states to 'start a food chart when [Mr A's] appetite is decreased'. The ARC contract, clause D16.3a stipulates that all staff follow the care plan. Sheaffs Rest Home resident nutrition and hydration policy states to 'introduce a fluid balance chart if there is a problem with fluid intake'. A fluid balance chart was started on [Day 17]. No other fluid balance charts were available with the Commissioner's documentation, neither was there a mention of maintaining a fluid balance chart in the progress notes. The family visited on [Day 8 – Day 9] and noted that [Mr A] had a sore mouth; this was not mentioned in the progress notes, although a painful mouth could have added to a reduced food and fluid intake. The progress notes do not indicate if a Registered Nurse was made aware of [Mr A's] sore mouth. The staff roster indicates that an RN was not rostered between [Day 8 to Day 11], however, Registered Nurse advice by phone may have been sought but this was

not evident from the progress notes. The care plan also notes for [Mr A] to be weighed weekly, however a weekly weight chart or mention of weekly weight in the progress notes was not available. [Ms B] states in her reply to the Commissioner's Office on the 4th of August 2011 that [following the time of Mr A's stay at the rest home], staff completed in-service education related to care and nutrition. Additional education is commendable and this may assist in the care for future residents. Staff education records were not available with the documents reviewed, therefore I am unable to determine if staff were knowledgeable about the management of nutrition and hydration at the time of [Mr A's] stay at the rest home.

Generally Aged Care facilities have policies to guide the management of nutrition and hydration and Sheaffs policy was available. In the absence of explicit policies or guidelines or when further advice is required, this is available in The New Zealand RN Care Guide for Residential Aged Care (2009) which notes that 1st line treatment for poor nutrition and hydration is to initiate a food and fluid balance chart and assess contributing factors. Advice is also available via Elderhealth services at District Health Boards.

As a food and fluid intake chart was not completed when [Mr A's] appetite declined and the progress notes were not completed each day or duty, I am unable to find conclusive evidence of [Mr A's] exact food intake and have to conclude that the management of [Mr A's] nutrition and hydration intake was not consistently monitored and therefore remedial actions may have been delayed. The management and monitoring of [Mr A's] hydration and nutritional status is in my opinion a mild departure from expected standard of practice.

Medication management

The rest home staff appropriately signed the medication signing sheets each time medication was given. The printed medication chart however was dated as commenced on the [day of admission] and signed in the 'doctor' section. According to the GP, [Dr F], [Mr A] was first registered with her on [Day 12] and was seen by the GP on that day. This gives the impression that the chart was signed on this GP visit on [Day 12], 11 days after admission. It is not best practice to administer from a chart not signed by a GP. Medicines must be authorised and signed by the Resident's medical practitioner according to the Ministry of Health 'Safe Medicine guide' (1997). According to the Age Related Residential Care Service Agreement (ARC Contract) clause D5.4, facilities are required to have a medication management policy. The GP reply noted that the GP visits occur once every fortnight. In order to prevent delay in the signing of medication charts, the facility may have a written policy or guideline to prevent delay in signing medication charts or work from original prescriptions in the first instance. The medication management policy was not available with the Commissioner's notes and I am therefore unable to determine if the rest home staff complied with their medication policy. The ARC contract D16.5e and the Sheaffs Rest Home admission policy note that a GP should see the resident within 2 working days of admission, unless the resident is seen by a medical practitioner 2 days prior to

admission. [Mr A] was discharged on [Day 1], a discharge summary completed by [Dr I] and prescription signed by [Dr J] on that day was available with the notes. In regards to medicine reconciliation when residents move between care providers, it is considered essential to check original prescriptions against the medication chart. [Mr A's] hospital prescription and hospital discharge summary note Tamsulosin 400mg once daily. The medication chart notes Tamsulosin 0.4mg. Tamsulosin is usually dosed at 0.4mg. There is no indication in the progress notes that facility staff observed or queried this discrepancy. If the facility staff worked from the original prescriptions until the medication charts were signed by a GP, the discrepancy in the dose of Tamsulosin should have been noted, rectified and documented. Paracetamol was signed as given on [Day 10]; there is no mention in the progress notes of the effectiveness of the Paracetamol. [Mrs A] noted that on the [Day 17] at her visit at lunchtime there was a Frusemide tablet on the tray. [Mr A] was charted Frusemide at breakfast and lunchtime. The medication chart is signed as given medication at both breakfast and lunchtime with no indication if [Mr A] was unable to take or had refused medication.

The medication management is in my opinion not aligned to best practice, as there is no clear indication that medication reconciliation occurred or when the medication chart was signed by the GP. I therefore conclude that the medication management was a moderate departure from expected standard of practice.

Whether medical intervention was sought appropriately

The ARC contract D16.5e and the Sheaffs Rest Home admission policy note that a GP should see the resident within 2 working days of admission, unless the resident is seen by a medical practitioner 2 days prior to admission. [Mr A] was discharged on [Day 1], a discharge summary completed by Dr I on that day was available with the notes. The GP letter explains what would be the ordinary practice when visiting a patient in a facility and the GP noted that this was the same when visiting [Mr A] on [Day 12]. [Mr A's] general frailty required astute monitoring and regular Registered Nurse evaluation and input. As RNs are not routinely staffed for each duty in rest home facilities, monitoring and follow up on poor hydration and nutrition may be guided by policies and guidelines of how to access Registered Nurse and GP support. It would be common practice that if a resident's health deteriorates, for instance poor nutritional intake or dehydration, that Registered Nurse and GP input would be sought. If a GP is not regularly visiting, GP practices are commonly accessed via phone or fax for further advice. At times, frail residents are admitted to a facility with the aim to initiate palliative care and appropriate medical input and medication changes are made. However it was not evident from the hospital or facility notes that palliative care was discussed with the family or [Mr A] until re-admission to the hospital. The medication chart and hospital discharge letter indicate active treatment. The progress notes indicate a decline in appetite and mood from [Day 5] onwards. It would have been appropriate to seek further advice from a Registered Nurse or Medical Practitioner at the time.

As there is no evidence in the progress notes of Registered Nurse input or advice sought from the GP before [Day 12], nor evidence of revision of the care plan despite a deterioration in [Mr A's] condition, I conclude that there was a moderate departure from expected standard of practice.

Care planning and implementation (including planning for end of life care)
A care plan was completed on the day of admission to Sheaffs Rest Home. The Sheaffs Rest Home resident admission policy point 2, stipulates that a comprehensive nursing assessment is completed together with the resident/relative/agent. The care plan, developed by a Registered Nurse, should reflect the assessment. Although there is a care plan dated [Day 1], [Mr A's] assessment was not available with the documentation supplied by the Commissioner's Office. Specific separate assessments related for instance to falls risk, continence and skin integrity were available. These separate assessments add to the fragmentation of an assessment and do not provide an overall comprehensive holistic view of the resident's needs or show the inter-connections between related concerns. For instance, the headings on the care plan such as 'mouth care', 'night care', 'cultural awareness' and 'spirituality' have instructions on the care plan, but it is not evident on which assessment this is based. The NASC assessment was faxed to the rest home on [Day 8], indicating that this assessment was not available to base a [day of admission] care plan on. There is an inter-hospital transfer form available with general information, however this would not be considered a comprehensive assessment to base a plan of care on. Domain 2.2 (competence for Registered Nurses as per New Zealand Nursing Council) states that an RN 'uses suitable assessment tools and methods to assist the collection of data' and 'applies relevant research to underpin nursing assessment'. It is reasonable to expect that a person with ongoing nutritional and hydration concerns is evaluated and the care plan adjusted accordingly. In a rest home setting, most care is provided by caregivers or Enrolled Nurses, with direction of and under the supervision of a Registered Nurse. On the day of [Mr A's] admission, the Registered Nurse worked a morning duty at the public hospital followed by an afternoon duty at Sheaffs Rest Home on the same day. Extended and/or double duties are not generally advisable as there is a risk of increasing fatigue (NZNO 2010). Registered Nurses may not be continuously available in rest home facilities, despite this, Enrolled Nurses and caregivers work under the supervision and direction of the Registered Nurse and usually have guidelines and protocols to identify health concerns and communicate these to the Registered Nurse in a timely fashion.

The organisational policy indicates that a care plan should be completed with input from the family. The care plan is ticked 'yes' as having family input, however [Mrs A] states she did not speak to a Registered Nurse and [Ms B] noted in a phone conversation with the Commissioner's Office on the 16th of November 2011 that [RN D] could not recall discussing the care plan with [Mrs A]. This implies that the plan was not made in partnership with the family. [Ms B] identified that a revised plan of care regarding [Mr A's] hydration was not formally discussed with [Mrs A]. The revised plan of care however was not

available with the Commissioner's Office documents. The Health and Disability Standards 8134.1.3:2008, standard 3.8.3 stipulates that where progress is different from expected, the service responds by initiating changes to the service delivery plan. Evaluation of the care plan is not available, despite [Mr A] having increasing nutritional and hydration concerns. New Zealand Nursing Council Competency for Registered Nurses, competency 2.6 specifies that a Registered Nurse should evaluate a client's progress towards expected outcomes. There is no clear evidence in [Mr A's] notes that his progress had been evaluated or plans adjusted accordingly. 'End-of-life-care' planning is not implied by the Sheaffs Rest Home care plan, neither is there an indication for palliative care in the progress or GP notes. The [hospital] notes from [Days 17-20] indicate a discussion about palliative/symptomatic treatment and intravenous fluids were administered during that admission.

A care plan is based on a Registered Nurse assessment, this care plan reflects the resident's care needs and guides care staff to provide appropriate care. Evaluation of care is completed when a resident's condition changes or deteriorates. Staff did not implement care as instructed by the care plan, for instance a food balance chart was not commenced when [Mr A's] appetite declined, weekly weight was not available and evaluation of care needs with revised instructions was not available to guide staff. I conclude that there was a moderate departure from expected standard of practice in relation to care planning.

Documentation

Accurate documentation is the basis to deliver continuous and appropriate care**.** Documentation of [Mr A's] care was not completed in a consistent manner; this has the potential to lead to fragmented care provision and delayed recognition of deteriorating condition.

For instance:

- There were no entries in the progress notes on [Days 3, 4, 6, 11, 16]. It is therefore not certain what care [Mr A] received during this time.
- The progress notes were not consistently signed with name and signature. Not all names were legible.
- The Sheaffs admission form was not signed or dated.
- The admission form was not completed, the diabetes diagnosis was not entered.
- On the admission form, 'Prostate' as diagnosis, no mention of what concern with prostate (enlargement, benign, malignant?).
- On the admission form it was noted that 'temp: normal, Resp. normal'. This is not a baseline recording and would not alert staff of any deviations from the norm specific to [Mr A].
- On the admission form, the section 'recordings dressings', there is no mention of the need for a dressing for [Mr A's] chronic wound.
- On admission form, 'Ethnicity' is noted as: 'Kiwi', this is not a recognised code for ethnicity and is colloquial language not suitable for health records.

- The Fluid Balance chart has a name only, no NHI or Date Of Birth unique identifier.
- GP signature in Medical notes not legible, no entry of time of visit.
- There is no record that the blood pressure, weight and pulse were recorded prior to GP visit. The GP states it is usual practice for the nurse to record these. The only recordings completed are on admission.
- Weight record on admission was 66.8 kg. [Mr A's] weight on re-admission to the hospital was 57.8 kg. At times there may be discrepancies in calibration of scales but this appears to be a marked weight loss. Because weight was measured on different scales, I am unable to determine the exact weight loss.
- [Mr A] was discharged from the hospital on [Day 1], and although this documentation was outside the rest home's control, the following was noted: the discharge summary was completed by [Dr I] and the prescription signed by [Dr J], although each document was completed by a different physician, the signature on both documents appear to be the same.[24]

Basic documentation advice is available to care facilities through the New Zealand Aged Care Association and the local DHB. The Sheaffs Rest Home Documentation policy was not available with the Commissioner's Office. However, the Enrolled Nurse job description stated as key responsibility 8 'Maintenance of clinical records' The Registered Nurse job description stated key responsibility 11 'Maintenance of clinical records'. The national Age Related Residential Care Contract stipulates that all entries into notes need to be legible, dated and signed with designation. New Zealand Nursing Council Competency for Registered Nurses, competency 2.3 specifies that Registered Nurses have to 'ensure documentation is accurate'. In my view, there is the appearance that attention to documentation related to [Mr A's] care is not consistently applied, hindering continuous care provision.

I conclude that there was a mild departure from expected standard of practice in relation to the documentation related to [Mr A's] care.

Thank you for the opportunity to comment and review this information. Please contact me if you require further information or clarification.

Yours Sincerely

Sylvia Meijer

References:

Aged Related Care Residential Care Contract, (2005–2010). Ministry Of Health New Zealand

[24] In her response to this advice, RN D noted that Dr I completed the prescription form and the Discharge Summary, and signed both. Dr J's name is at the top of the Discharge Summary and on the prescription form as the consultant whose care Mr A was under during his admission. Therefore the signatures are correct.

Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings retrieved 21 May 2011 from https://www.ecri.org/Documents/Patient.../BedSafetyClinicalGuidance.pdf

Diabetes testing information Retrieved 10 December 2011 from http://www.diabetesinfo.org.nz/bgtests.html

Ministry of Health, (2008), New Zealand Health and Disability Services Standards 8134:2008, author.

Ministry of Health (1997) Safe management of Medicine http://www.moh.govt.nz/notebook/nbbooks.nsf/0/7D7AAD3DF4303EA24C2565D7000E1EB3/$file/Safe%20management%20of%20medicines.pdf

NZ Guidelines Group, (2003), Management of Type 2 Diabetes.

Nursing Council of New Zealand, (2010) Competencies for Registered Nurses. Retrieved 8 December 2010 from http://www.nursingcouncil.org.nz

New Zealand Nurses Organisation (1997) Documentation guideline. Retrieved 8 December 2010 from http://www.nzno.org.nz/LinkClick.aspx?fileticket=8MknWhFVTnl%3D

New Zealand Nurses Organisation (2010), Rostering guidelines Retrieved 8 December 2010 from http://www.nzno.org.nz/services/resources/publications"

Ms Meijer was asked to review her advice in light of further information obtained from the providers. Her further comments are outlined below.

"**Health and Disability Commissioner** **4 January 2013**

HDC Reference: 11/00423

Thank you for the opportunity to further comment on the responses by [Ms B], Manager Sheaffs Rest Home, [RN D], Registered Nurse at Sheaffs Rest Home, as well as responses provided by care staff. The responses relate to the concerns about the care provided to [Mr A] while at Sheaffs Rest Home from [Day 1 to Day 17], HDC reference 11/00423.

[Ms B's] and [RN D's] responses relate to my initial advice made to the Commissioner's Office on 20 December 2011. My personal and professional profile, qualifications and clinical experience were stated in the initial advice and are therefore not repeated in this document. The findings are a result of reading through the additional information provided by the Health and Disability Commissioner's Office, reviewing the relevant literature and my own professional clinical experience of working with older adults. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I do not have a conflict of interest with the parties involved.

In my reply, the Commissioner's Office question is posed in 'bold' with my response directly following each question. The Commissioner's Office provided additional documents and asked for further comments on:

- The information provided by [Ms B] and [RN D] in relation to medication management.
- The information provided by [RN D] in relation to completion of [Mr A's] initial care plan and nursing assessment.
- [RN D's] response to the concern raised about wound care management, including training in wound care management.
- The responses from [RN D] and [Ms B] in relation to your concern about documentation.
- [RN D's] explanation for BSL testing regime followed by Sheaffs Rest Home.
- The information provided by staff regarding [Mr A's] reluctance and/or refusal to eat.
- The systems/arrangements in place at Sheaffs Rest Home for staff to communicate resident's care needs and changes in condition.
- The changes made at Sheaffs Rest Home since and/or in response to these events, including:
  - The introduction of new wound care documentation.
  - The introduction of a care plan assessment form to be used by caregivers during the first week of a resident's admission.
  - The updated Medicine Safety Management Protocol.
  - The changes to practice outlined by [RN D].

In light of the additional information, the Commissioner's Office also requested to identify any changes to my previous advice and if so, to identify if this would change the severity of the departure from expected standard of care. In reply to this, the initial question is posed in 'bold' with my response to any changes from the initial advice directly following.

- **The information provided by [Ms B] and [RN D] in relation to medication management.**

The reconciliation of the medication, particularly the incorrect dosage of Tamsulosin, was corrected by [the pharmacy] according to [Ms B], however this was not evident in the initial documentation provided, neither on the chart nor in the progress notes. [Ms B] explains that it was her decision to wait until the GP could sign the medication chart and follow up with the GP on [Day 12], 10 days after [Mr A] was admitted. Medication can only be administered when signed by a GP or Nurse Practitioner and Registered Nurses or competent Care staff are required to check if medication is signed on the medication chart each time they administer a medication to a resident. [RN D] did not specifically comment on the medication management related to [Mr A's] care. The organisation has since updated the medicine management protocol and this ensures that similar reconciliation issues are less likely to recur. The policy also states in the second paragraph '…as prescribed by the medical practitioner'. The medication management at the time of [Mr A's] care is in my opinion not aligned to best practice, as there was no clear indication that medication reconciliation occurred and there was a 10-day delay in the GP signing the medications on the chart. Administering unsigned medication is considered a risk to resident and staff. I

therefore conclude my initial advice is unchanged and that the medication management was a moderate departure from expected standard of practice.

- **The information provided by [RN D] in relation to completion of [Mr A's] initial care plan and nursing assessment.**

The initial care plan and progress notes documentation did not reveal that [RN D] had a conversation with hospital staff about [Mr A's] care needs. [RN D's] intention to contact the family was however not followed-up at the time because of family being unavailable. [RN D] noted she would have contacted the family prior to completing the full care plan. The initial care plan was completed on the day of admission and [RN D] correctly identifies the contractual time frame for the completion of a care plan. As noted in my initial advice, a care plan, developed by a Registered Nurse, should reflect an assessment. Although there was a care plan dated [Day 1], [Mr A's] assessment was not available with the initial documentation supplied by the Commissioner's Office and [RN D] explained she used the discharge summary, the transfer form and verbal information from [Mr A], [Ms B] and Enrolled nurse [EN E] to inform her. There was no initial Sheaffs Rest Home assessment or baseline recordings documentation available to show the basis for the initial care plan. Baseline recordings such as temperature and respirations where recorded as 'normal', this did not indicate what was 'normal' for [Mr A] or would alert staff to any deviations from 'normal'. [RN D's] notes on changes made since the incident indicates a more robust system to ensure appropriate assessment and initial care planning and would mitigate similar events occurring.

- **[RN D's] response to the concerns raised about wound care management, including training in wound care management.**

[RN D's] reply indicated that she had seen the wound and supervised the caregiver [Ms H] with the dressing. This was not evident in the initial notes or the wound care plan. According to the in-service education record, [Ms H] received 1¾ hour of wound care education by the nurse educator of the hospital (1 hour pressure area/documentation and ¾ hour wound care). The dressing material used was noted on the wound care chart. As a caregiver signed the wound care chart off, the initial documentation gave the impression that no Registered Nurse involvement had been sought, or that a Registered Nurse was regularly reviewing the wound. It is not common practice that a caregiver would assess a wound and initiate a wound dressing and/or select the wound dressing material. The organisation has since increased the RN hours and this would assist in wound assessment and supervision of staff dressing wounds. In relation to the training in wound care management, [Ms H] is a qualified caregiver and did attend 1¾ hours of additional wound care education. It is accepted practice that wound assessment and ongoing wound care is the domain of Registered staff, although in a rest home setting, uncomplicated wounds are sometimes dressed by caregivers, under the supervision and delegation of the Registered Nurse and with regular Registered Nurse wound assessments. This would be stipulated in the care plan. Although helpful for caregivers to have some knowledge about wound care, it is my view that 1¾ hours

of wound care education is very minimal and would not suffice to assess wounds, select appropriate dressings and monitor and evaluate progress. However, it is my understanding from the reply, that the organizational policy allows care staff to do wound dressings and I expect wound management to be within the contractual, legal and best practice requirements for rest homes.

- **The responses from [RN D] and [Ms B] in relation to your concern about documentation.**

The organization reviewed their documentation processes to ensure documentation is consistent and care communicated better. [Ms B] and [RN D] comment that communication is via resident notes, handover notes, communication book and whiteboard. The many different places information is documented may remain to cause fragmentation of care. It is my understanding that under contractual requirements, documentation will be regularly audited and any further issues identified. The additional information provided a staff signature list and explanation of signatures on discharge letters. The reviewed documentation and communication processes mitigate similar issues recurring.

- **[RN D's] explanation for BSL testing regime followed by Sheaffs Rest Home**

The additional information provided a good rationale for BSL testing and identified the GP and the DHB diabetes nurse as resource for practice. I agree that 3 times a day testing for a stable diabetic resident would suffice. [Mr A's] care plan stated to test three times daily on Mondays. The 'Bloodsugar and insulin form' showed that on [Day 5 and Day 7], BSLs were tested only twice and Day 16 only once. On [Day 7] [Mr A] was taken to a hospital appointment and this may have been the reason for missing one BSL. There is no indication in the progress notes why the other BSL recordings have not been taken. The care plan also noted to 'administer diabetic medication as prescribe'. [Mr A] did not have any diabetic medication prescribed.

- **The information provided by staff regarding [Mr A's] reluctance and/or refusal to eat.**

The hospital notes indicated depression and this is likely to have influenced [Mr A's] eating patterns. Staff indicated in interview that [Mr A] did not always complete his meals and often refused and although this indicated that staff was aware of his poor intake, no further action was taken. The notes did not provide a clear indication of his exact food and fluid intake. It is accepted practice that a food/fluid chart is commenced for monitoring purposes, and RN/GP/ dietitian input is sought if a resident's intake is poor.

- **The systems/arrangements in place at Sheaffs Rest Home for staff to communicate resident's care needs and changes in condition**

The review of communication of resident's needs is commendable. The initial care plan form is appropriate to guide staff in the care of a new resident. The emphasis

on handover is an opportunity for staff to ask questions about the required care. Additional Registered Nurse employment and changes to roster to ensure 7 days a week of regulated staff cover promotes continuity of care.

- **The changes made at Sheaffs Rest home since and/or in response to these events, including:**
    - **The introduction of new wound care documentation.**
      The wound map and assessment form are appropriate to ensure that similar issues are less likely to recur.
    - **The introduction of a care plan assessment form to be used by caregivers during the first week of a resident's admission.**
      The nursing assessment and care plan forms provided (page 324–330, QAN 7.0 and Qan 12.0) are suitable as an initial assessment and care plan to guide care staff and ensure that similar issues are less likely to recur. Both [Ms B] and [RN D] identified the contractual requirements for assessment and care planning. From the documentation provided it is my understanding that at Sheaffs Rest Home a Registered Nurse completes these forms and care staff use this information to provide the appropriate care. It is general practice in care facilities that Registered Nurses discuss care plans with care staff. The Registered Nurse remains responsible for the assessment of the resident and the development of the care plan.
    - **The updated Medicine Safety Management Protocol.**
      The updated version details medication management and particularly medicine reconciliation appropriately to ensure that similar issues are less likely to recur.

      Although not related to [Mr A's] care, I would like to suggest the organization verifies with the regular prescriber the appropriateness of the 'Standing order' page 15 of the policy. Specifically, if the competency level of caregivers will suffice to make decisions about the initiation of all the medications noted in the Standing orders. Also the oral thrush and the creams and ointments may require verification. These medications are usually prescribed for certain conditions, require a diagnosis and are usually given as a course for a certain length of time. Skin conditions can be caused by underlying health concerns that may need to be addressed, the diagnoses of skin conditions are generally made by medical staff. Legally, standing orders require to be signed by a Medical Practitioner/GP. The organization may like to consider dating the policy and the review period, as well as identifying all the resources and references used to update this policy. This would clearly identify the underlying Evidenced Based practice that the organisation adheres to.
- **The changes to practice outlined by [RN D]**

The changes [RN D] made to her practice as outlined in her reply, assist in mitigating further concerns/incidents, and support safe and appropriate patient care.

Questions posed in the initial advice:

Concerns about the care provided by Sheaffs Rest home
Considering the additional information provided, evidence showed that [Mr A] was at times reluctant to take food. The hospital notes also indicated [Mr A] had developed depression in response to his physical health problems. My initial comments related to communication, and assessment still stand. However, in view of the additional information I am changing my opinion to: The care provided to [Mr A] during his stay at Sheaffs Rest Home is in my opinion a mild departure from expected standard of practice.

Monitoring and management of nutrition and hydration
The progress notes provide an indication that [Mr A] required assistance with meals and that at times he refused food. [Mr A's] exact food intake was not clearly evident, although staff mentioned that at times he refused food and fluid. It is my conclusion that the management of [Mr A's] nutrition and hydration intake was not consistently monitored and therefore remedial actions may have been delayed. My initial advice is unchanged: the management and monitoring of [Mr A's] hydration and nutritional status is in my opinion a mild departure from expected standard of practice.

Medication management
As noted previously in this document, the medication management at the time of [Mr A's] care is in my opinion not aligned to best practice, as there is no clear indication that medication reconciliation occurred and a 10 day delay in signing the medication chart by the GP. My initial advice is unchanged: the medication management was a moderate departure from expected standard of practice.

Whether medical intervention was sought appropriately
[Mr A's] general frailty required astute monitoring and regular Registered Nurse evaluation and input. It would be common practice that if a resident's health deteriorates, for instance poor nutritional intake or dehydration, that Registered Nurse and GP input would be sought. If a GP is not regularly visiting, GP practices are commonly accessed via phone or fax for further advice. The hospital admission documentation noted serious dehydration. As there is no evidence in the progress notes of Registered Nurse input or advice sought from the GP before [Day 12], nor evidence of revision of the care plan despite deterioration in [Mr A's] condition, my initial advice is unchanged: I conclude that there was a moderate departure from expected standard of practice.

Care planning and implementation (including planning for end of life care)
A care plan is based on a Registered Nurse assessment, this care plan reflects the resident's care needs and guides care staff to provide appropriate care. The additional information supplied by [RN D] and the rationale for the initial care plan is reasonable. The organization's new initial care plan is commendable and mitigates similar situations recurring. The additional information from care staff also indicated that care plans are not always used to guide daily cares. It is common practice that evaluation of care is completed when a resident's condition changes or deteriorates. Staff did not implement care as instructed by the care plan, for instance a food balance chart was not commenced when [Mr A's]

appetite declined, weekly weight was not available and evaluation of care needs with revised instructions was not available to guide staff. My initial advice is unchanged: I conclude that there was a moderate departure from expected standard of practice in relation to care planning.

Documentation
Accurate documentation is the basis to deliver continuous and appropriate care. Documentation of [Mr A's] care was not completed in a consistent manner; this has the potential to lead to fragmented care provision and delayed recognition of deteriorating condition. The organization reviewed their documentation and implemented safeguards to ensure documentation is timely, appropriate and care communicated better. Documentation remains in a number of different places, such as resident notes, handover notes, communication book and whiteboard, which may continue to cause fragmentation. My initial advice is unchanged: I conclude that there was a mild departure from expected standard of practice in relation to the documentation related to [Mr A's] care.

Thank you for the opportunity to further comment and review this information. Please contact me if you require further information or clarification.

Yours Sincerely

Sylvia Meijer

Current and previous references used to review information:

Aged Related Care Residential Care Contract, (2005–2010). Ministry Of Health New Zealand

Diabetes testing information Retrieved 10 December 2011 from http://www.diabetesinfo.org.nz/bgtests.html

Ministry of Health, (2008), New Zealand Health and Disability Services Standards 8134:2008, author.

Ministry of Health (1997) Safe management of Medicine http://www.moh.govt.nz/notebook/nbbooks.nsf/0/7D7AAD3DF4303EA24C2565D7000E1EB3/$file/Safe%20management%20of%20medicines.pdf

Ministry of Health, (2011), Medicine Care Guide for residential aged care. Author: Wellington

NZ Guidelines Group, (2003), Management of Type 2 Diabetes.

Nursing Council of New Zealand, (2010) Competencies for Registered Nurses. Retrieved 8 December 2010 from http://www.nursingcouncil.org.nz

New Zealand Nurses Organisation (1997) Documentation guideline. Retrieved 8 December 2010 from http://www.nzno.org.nz/LinkClick.aspx?fileticket=8MknWhFVTnI%3D

New Zealand Nurses Organisation (2010), Rostering guidelines Retrieved 8 December 2010 from http://www.nzno.org.nz/services/resources/publications

RN Care Guide, Waitemata DHB (2009). Retrieved 8 December 2010 from http://www.wdhb-agedcare.co.nz"