Registered Nurse, Ms C

Rest Home/Hospital Company

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC06457)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Ms B	Complainant
Ms C	Registered Nurse
Ms D	Registered Nurse
Ms E	Enrolled Nurse
Ms F	Health Care Assistant
Ms G	Health Care Assistant
Ms H	Health Care Assistant
Ms I	Director, the Hospital
Ms J	Nurse-Manager & Director, the Hospital
Dr K	The Hospital's on-call GP
Dr L	Locum GP
Rest Home/Hospital	The Hospital

Complaint

On 28 April 2006 the Commissioner received a complaint from Mrs A's daughter, Ms B, concerning the Hospital. The following issue was identified for investigation:

> *The appropriateness of the care provided to Mrs A by RN Ms C and the Hospital on 16–17 January 2006, in relation to Mrs A's dislocated hip.*

The investigation was commenced on 27 October 2006.

Information reviewed

- Patient Progress Notes for Mrs A
- Transcript and recording of 16–17 January 2006
- Statements from:
  - Ms C, Registered Nurse
  - Ms E, Enrolled Nurse
  - Ms F, Health Care Assistant
  - Ms H, Health Care Assistant
  - Ms D, Registered Nurse
  - Ms G, Health Care Assistant
- Report of internal investigation by the Hospital's management team

- Report from Ms Robyn Northey, Aged Care Consultant
- Policy and Guidelines from the Hospital

Independent expert advice was obtained from Ms Jan Featherston, Nurse (with considerable experience in aged care).

Information gathered

Background
On 17 December 2005, Mrs A, then aged 79, was moved by her family from another rest home[1] to the Hospital, a 40-bed licensed hospital providing medical, postoperative and convalescent care run by the Rest Home/Hospital Company.

Mrs A had Parkinson's disease. Additionally, in 2000 she had received a total right hip joint replacement, and she had subsequently suffered a number of hip dislocations.[2] Mrs A resided at the Hospital until 17 January 2006, when she was transferred to a public hospital following the dislocation of her right hip.

Recording and transcript
Mrs A's family placed a hidden voice-activated recording device in Mrs A's room at the Hospital. The family subsequently provided this Office and the Hospital with a copy of the recording, which included material obtained on the night of 16 January 2006. The Hospital provided this Office with their transcript of this recording.

On the copy of the recording, it is not possible to establish the chronological times for each separate voice-activated recording. The recording sent to this Office shows it as starting from 5.03pm, and lasting 1 hour and 23 minutes. Registered nurse Ms C, in her response to this Office, stated that she had heard the recording and seen the Hospital's transcript, and was "positive that that tape is an edited version of the full interactions which went on [on] 16th and 17th January". Registered nurse Ms D noted that on 16 January 2006 at 11pm, she asked Mrs A whether she required pain relief, and Mrs A told her that she did not need it. Mrs A also asked her who she was and she responded with her name. The resident's progress notes document that Ms D "[o]ffered panadol 1gm at 2300 HRS — refused meantime". However, these interactions are not on the recording or noted in the transcript.

[1] Mrs A's family were concerned that her care at this rest home had not been of an appropriate standard and alleged that a staff member had physically assaulted her. This matter has been the subject of a separate investigation.

[2] Mrs A's medical records show that her hip had dislocated seven times. Mrs A indicates on the voice-activated recording of 16 January 2006 that the dislocation that occurred that evening at the Hospital was her thirteenth hip dislocation.

Notwithstanding any concerns about the complete accuracy of all the material provided or the placement of such a device and the gathering of information in this way, I am satisfied that it is appropriate for me to consider the transcript as providing a record of events following Mrs A's hip dislocation, along with the contemporaneous records. The transcript of the recording is for the most part consistent with the information I have obtained from the parties involved. My staff have listened to the recordings provided by Ms B, and I have listened to key excerpts. I am satisfied that, while not a complete record of events, the transcript provides a reasonably accurate representation of the events on 16 and 17 January 2006.

Events of 16 January 2006

The evening nursing shift at the Hospital on 16 January started at 3pm and ended at 11pm. The person on duty with clinical responsibility for Mrs A at the time of her hip dislocation was registered nurse Ms C. Also on duty at this time were enrolled nurse (EN) Ms E and three health care assistants (HCAs), Ms F, Ms G and Ms H. Ms C had overall clinical responsibility for the residents on site and supervised the work of the HCAs.

Ms H explained that she was on duty in another part of the hospital during this shift. Ms G advised that her allocation of duties during this shift meant that she worked only briefly with Mrs A that evening.

It is not known precisely how or when Mrs A dislocated her hip. However, the transcript of the recording documents that Mrs A called for help at about 7.30pm, when she was standing next to her bed, and out of reach of her emergency bell. The transcript provided by the Hospital reads:

> "19.38: [Mrs A] Anybody there? Hello? Help I need to be in hospital, help, I need a Dr and a hospital, help, who can help, [Mrs A] here, hello, help, nurse please help I'm slipping down …"

On the recording provided by Ms B, Mrs A can be heard calling continuously for assistance for approximately four minutes. After three minutes of calling loudly for help, Mrs A sounds as if she is becoming increasingly distressed, tired, and incoherent. Shortly after this, a trolley is heard approaching her room and someone responds. In her statement, HCA Ms F said:

> "I heard [Mrs A] calling out. I went in to check and saw her standing up near her fridge which was opened, with one hand holding on to her walking frame and one hand holding on to the fridge as [if] she was putting something in the fridge."

Ms F thought Mrs A was calling out because she required assistance with toileting. (A combined bathroom and toilet facility was a short distance along a corridor from her room.) However, the transcript records Mrs A telling Ms F that her hip had gone again. On the recording, Mrs A's words are indistinct. It sounds as if she said, "My hips are funny." Ms F said she sat Mrs A on a chair and went out of the room to gather

towels in preparation for washing her. According to Ms F, when she returned to the room EN Ms E was with Mrs A. On the recording, after Mrs A is sat down she is asked whether she can stand up and walk. She replies, "I've had 12 of these." Asked if she means that day, Mrs A says no. She agrees she is referring to her hip replacement.

The transcript and the recording indicate that Mrs A was taken to the toilet, and there was some discussion between Ms E and two HCAs (Ms F and Ms G) about the condition of Mrs A's hip and foot. There seems to be an attempt by Ms E and one of the HCAs to walk Mrs A to the toilet, but Mrs A was unable to walk. Ms E explained that she then put Mrs A on the toilet chair. Mrs A complained of pain in her right hip and, at that point, Ms E noticed that Mrs A's leg "was in an unusual position". The transcript indicates that Mrs A experienced some discomfort and a moment of acute pain while carrying out these activities.

Ms C explained that she went to Mrs A's room during her 8pm medication round. The transcript records Ms C asking where Mrs A was. Ms C was advised (by an unidentified HCA) that Mrs A was in the toilet, and Ms C stated that, on hearing this, she carried on with her medication round.

Ms C said that at 8.20pm she was called from the nurses' station by Ms E, who told her that Mrs A's hip was sore. Ms C noted:

> "I was aware that [Mrs A] had had about 12 right hip dislocations previously, following on from an unsuccessful right hip replacement operation. These dislocations occurred before her time at [the Hospital]."

At 8.22pm the transcript records Ms C returning to Mrs A's room. This is clearly heard on the recording. By this stage Mrs A had been returned to her bed. Ms C stated:

> "I arranged for [Mrs A] to lie flat, as she was partly over on one side when I arrived. I lined her legs up and did a visual assessment. The right leg was clearly shorter than the left and was rotated. It was very obvious that there was a problem with her leg. My initial assessment was that the hip was probably dislocated.
>
> I spoke to [Mrs A], and asked her whether it felt like it had with the previous dislocations. She indicated that it did.
>
> We did not move the leg other than … when necessary to position [Mrs A]. On movement, she expressed discomfort, but when she was still there was no indication of pain. [Mrs A] was not distressed.
>
> I spoke to the enrolled nurse and caregiver about positioning for [Mrs A] and the use of pillows, to support and immobilise the leg."

Ms C then attempted to telephone the Hospital's on-call GP, Dr K. Unable to contact him, she left a voice message on his cell phone. She returned to the room and informed

Mrs A that she had left a message with the doctor. Before completing her shift, Ms C left a second message for Dr K concerning this matter. She also left a message for Mrs A's daughter, Ms B, on her answerphone. Ms B informed me that she received the following message, logged at 10.15pm:

> "[Ms B], it's [Ms C] at [the Hospital] here. I'm just ringing about your mum [Mrs A]; her right hip is in pain. I have tried to … ummm … it does look like there is some sort of positional change. I have tried to get hold of [Dr K] but have, as yet, not been able to. I have left a message on his cell-phone so I'm expecting a call from him soon. Bye for now."

The Hospital had medical cover available and it was the role of the registered nurse to contact the on-call doctor. Any additional information, such as locum cover, was handwritten in note form and attached to the front of the "patient notes trolley". The Hospital's policy for contacting doctors stated:

> "Should our contracted medical services be unavailable by cell phone and landlines, and should the registered nurse be sufficiently concerned re[garding] a patients' well being, the 24 hour House Calls Services may be contacted …"

Ms C stated that it was not standard practice at the Hospital for there to be a written handover. Therefore, at the end of her shift, Ms C gave a verbal hand-over to the night-shift RN, Ms D. Ms C stated:

> "I informed the night staff that I had not yet heard back from [Dr K] and that I had left a message for [Mrs A's] daughter … At no time did I feel that [Mrs A] required urgent attention — she was comfortable and not distressed. From my experience … it has been considered less distressing for the patient to be kept comfortable in a familiar place than transferred in the middle of the night, and in all probability have no treatment until the morning."

Ms C advised me that before she finished her shift at 11.00pm she checked on Mrs A a number of times, and Mrs A was sleeping.

Night shift

Ms D stated that she checked on Mrs A through the course of the night, and Mrs A was sleeping soundly and looked comfortable. In the resident's progress notes it is recorded that she offered Mrs A paracetamol, which Mrs A refused. Ms D said that at about 1.15am she turned Mrs A, who only expressed minor distress at being moved. This interaction is recorded on the transcript at 1.23am. Little can be heard on the recording after this, until Mrs A asks the time and is told it is five o'clock. At 5.30am, Ms D documented in the resident's progress notes that Mrs A was comfortable. She stated:

> "We made sure that [Mrs A] was comfortable (not damp) and we used pillows to support her R[ight] leg — one on each side and underneath her leg to elevate it slightly. She spoke to us and we to her."

The night shift ended at 7.00am. The resident's progress notes document that a call was received from Ms B concerning her mother. Ms B explained:

> "I rang [the Hospital] and was told that Mother had complained of discomfort at around 10pm, had a comfortable night and refused Paracetamol."

Events of 17 January 2006
On the morning of 17 January 2006, Ms C returned to duty at 8am and was advised that there had been no contact from Dr K. Ms C discussed this with a colleague, who informed her that Dr K was away on leave. As stated earlier, amended information concerning the on-call doctors' availability was normally attached by tape to the "patient notes trolley". The Hospital advised me that in this case the information had been attached in this manner, and it is presumed to have worked loose and subsequently been lost. The Hospital acknowledged that Ms C was not aware until that morning that a locum was covering for Dr K.

Ms C said:

> "I rang [Dr L], who was covering for [Dr K]. She said that [Dr K's] locum at his surgery was handling his patients during the day, rather than her. So I rang the surgery … and spoke to a doctor there. I explained that the night before [Mrs A] had had a suspected hip dislocation. The doctor asked if [Mrs A] was comfortable, and I said she was. The doctor said she'd come after morning surgery and she asked me to ring for a portable X-ray … [Dr L] phoned to say she would come in [to the Hospital] on her way to her surgery."

Ms C said she checked on Mrs A throughout the morning and on one occasion discussed with her how her hip was. This conversation is heard on the recording and reported in the transcript. The time is heard to be stated as 8.30am.

At 9am the portable X-ray arrived and an X-ray was taken. The X-ray technician discussed this with Mrs A, informing her that the picture clearly shows her hip is dislocated. This is on the recording. The X-ray report described it as a "posterior dislocation of the femoral component of the right hip replacement".

Dr L
Dr L arrived as arrangements were in progress for Mrs A to be transferred to hospital. Dr L reviewed Mrs A's clinical notes concerning her hip dislocation, and said she was satisfied that the steps taken by the registered nurses to assess and manage Mrs A's injury overnight were appropriate. Dr L arranged for Mrs A to be admitted to the public hospital.

During the investigation, Dr L commented that it would have been good practice to have had Mrs A medically reviewed at the time when the hip dislocation was first recognised. However, she noted that a doctor called out at night might still have made a clinical decision to leave Mrs A at the Hospital. Dr L noted that this would be

reasonable practice as long as Mrs A was comfortable and her pain relief was appropriate.

Ms B
Ms B arrived to see her mother at approximately the same time as Dr L. Ms B stated:

> "When I walked into Mother's room at [the Hospital] on Tuesday morning, I honestly thought she was dead. Several people were in and out of her room, Mother's eyes were closed, her mouth agape, she was very pale and looked utterly ghastly. When I spoke to her she appeared delirious and made little sense when she tried, with very limited success, to speak."

At approximately 10.20am, Mrs A left [the Hospital] and went to the public hospital with her daughter. On Mrs A's discharge from the public hospital, Ms B cared for her mother at home.

Additional information from the Hospital
In relation to the training of HCAs, the Hospital advised that, at the time of the events under investigation, HCAs had not been clearly informed about Mrs A's condition. HCAs would listen to the RN's report on the residents under their care at the beginning of the shift, but they did not receive additional training or education concerning the residents' specific health problems. The role of the registered nurse, and their responsibilities for supervising HCAs, were not outlined in any of the Hospital's manuals.

The Hospital noted that their staff did not clearly document their actions over the night of 16/17 January. The Hospital advised that the expectation was that any significant event that occurred during a shift would be recorded in sufficient detail in the patient progress notes. Registered nurses were expected to read these notes at the start of their shift.

The Hospital's incident policy in early 2006 was that incidents should be accurately reported on an incident form as soon as possible. The Hospital provided two incident reports concerning Mrs A's hip dislocation. These were completed by Ms C (dated 17 January 2006) and Ms D (dated 20 February 2006).

Subsequent events
On 2 February 2006, Ms J, the Hospital's Nursing Manager, met with Mrs A's family to discuss her hip dislocation. At this meeting, the family provided the Hospital with the taped material, which raised concerns about the behaviour of some staff members towards Mrs A. This included Mrs A being treated with a lack of respect and being spoken to in a manner that Ms B described as verbally abusive.

On 7 February 2006, Ms J informed the Commissioner of the Hospital's intention to investigate the family's concerns. The investigation identified seven staff members whose conduct or work performance (with regards to Mrs A) was deemed to be of an inappropriate standard, and identified 52 specific areas of concern. The individual staff

members listened to the recordings and were provided with an opportunity to respond. The appropriateness of the conduct was discussed with each staff member, and remedial actions were taken, including disciplinary action in some cases. However, Ms B was not satisfied with the Hospital's investigation and referred her complaint to this Office on 26 April 2006.

Ms Northey's report
On 15 June 2006 the Commissioner asked Ms Robyn Northey, a consultant with extensive experience in aged care, to independently review the Hospital's response to Ms B's complaint. Ms Northey has provided expert advice on rest home matters to the Commissioner on a number of occasions. In this instance, Ms Northey was asked to provide her opinion as to whether the Hospital's internal investigation was thorough, and whether the recommended actions arising out of the investigation had been undertaken and were effective. She concluded that the Hospital's investigation into this matter had been thorough and that it had taken action to address the concerns raised. Ms Northey recommended that the Hospital increase its level of staff training, and the Hospital has undertaken this. Ms Northey also expressed the view (after discussion with a geriatrician) that Mrs A should have been seen by a doctor immediately after her hip dislocation was identified.

Responses to my provisional opinion

The Hospital's response
The Hospital advised me that they accept the breach finding, and clarified some factual matters in relation to action taken in response to the complaint.

The Hospital provided a letter of apology to Mrs A's family. They wrote:

> "In spite of being both accredited with Quality Health New Zealand and certified with Ministry of Health, we failed to give [Mrs A] the care she was both deserving of, and entitled to."

The Hospital has accepted that there were failings in the manner in which some of their staff provided care to Mrs A. They have taken corrective actions to improve their standard of care as a result of this complaint. They note that they now monitor more closely the level of care their staff provided to residents, particularly those who are vulnerable, or unable to act or speak for themselves.

Ms B's response
Ms B noted that the Hospital had accepted the breach findings. She indicated that she believes the Hospital has "got off very lightly", but she has decided not to pursue matters further.

Independent advice to Commissioner

The following expert advice was obtained from Jan Featherston:

"I have been asked to provide an opinion to the Commissioner on Case 06HDC06457. I have read and agree to follow the Commissioners' Guidelines for Independent Advisors.

Enclosed is a copy of my qualifications which outline my training and experience relevant to the area of expertise to be called upon in compiling this report.

Complaint *The appropriateness of the care provided to [Mrs A] by RN [Ms C] and [the Hospital] on 16–17 January 2006, in relation to [Mrs A's] dislocated hip*

Supporting documentation

- Letter to the Commissioner from [Ms B], dated 26 April 2006, marked 'A' (Pages 1–4).
- Report from [the Hospital], Complaint Investigation (Pages 1–11), marked 'B' (Pages 5–15).
- Notification letters to [Ms B], [Ms C] and [the Hospital], marked 'C' (Pages 16–27).
- Response to Deputy Commissioner from [Ms C], dated 20 November 2006, marked 'D' (Pages 28–36).
- Response to Deputy Commissioner from [the Hospital], marked 'E' (Pages 37–42).
- Statements from [the Hospital] staff, marked 'F' (Pages 43–51).
- [Mrs A's] Resident's Progress Notes, marked 'G' (Pages 52–67).
- Copies of [the Hospital's] relevant policies and guidelines marked 'H' (Pages 68–101).
- Copy of [the Hospital's] staff orientation and training material, marked 'I' (Pages 102–109).
- Copy of [the Hospital] Health Care Assistant job description, marked 'J' (Pages 110–120).
- Copy of [the Hospital] Enrolled Nurse job description, marked 'K' (Pages 121–131).

Background

[Mrs A] was admitted to [the Hospital] following family concerns over care issues at another facility.

[Mrs A] required Hospital level care due to multiple medical problems:

- Recurrent right hip dislocations

- Recurrent falls secondary to impaired postural reflexes, postural hypotension and Parkinson's disease
- Urinary Tract Infection
- Parkinson's disease with likely Lewy body Dementia
- Hypokalaemia secondary to fludrocortisone

[Mrs A] was on a number of medications.

Expert advice required:

1. In your professional opinion were the services provided to [Mrs A] by registered nurse [Ms C] in relation to [Mrs A's] hip dislocation appropriate?

Nurse [Ms C], I believe, carried out her duties to a reasonable standard. The clinical progress notes state:

"Returned from outing with daughter — walking fine. When got up from toilet @ 2030 unable to weight bear on R side R hip is painful and L rotating internally, Left message on [Dr K's] cell phone and left message for daughter on answer phone"

In Nurse [Ms C]'s statement (number 045–047) she states that [Mrs A] was in bed when she examined her leg. It was internally rotated and shortened. She states that [she] was not distressed and expressed discomfort when her leg was moved.

Nurse [Ms C] stated and documented that she identified that [Mrs A's] R leg was rotating internally and shortened.

As was appropriate Nurse [Ms C] rang, who she thought was the on call doctor, and left a message for him to contact the hospital. She then informed [Mrs A] of this.

Nurse [Ms C] asked the enrolled nurse to check on [Mrs A] to see if she required any pain relief. The enrolled nurse reported back that she was asleep; [Mrs A] was again asleep when she was checked at 10pm.

Nurse [Ms C] again rang at 9.51pm and left another message for the Doctor to contact the hospital.

Nurse [Ms C] did a round with the night staff explaining what she had done.

On returning to work the following morning she was informed that [Dr K] was in fact away on holiday and that there was another doctor covering for his patients. Nurse [Ms C] then contacted the other doctor who provided care, to be told that she would have to ring [Dr K's] locum. This she did but only to be informed that she [Dr L] would not be able to visit until after 12pm.

[Dr L] then called and said she would call in on her way to work and could a portable X-ray be done.

The X-ray was done and it confirmed a dislocated hip.

The doctor arranged for admission to [public hospital].

It is my opinion that Nurse [Ms C] carried out her duties in a satisfactory manner.

I do not believe that there has been a breach of the competencies required of registration of Registered Nurses.

Comment

I believe that it was appropriate for [Mrs A] to stay at [the Hospital] overnight. The clinical notes indicate that she had a comfortable night, and this is also confirmed in Registered Nurse [Ms D's] statement (pages 049–051). In an ideal world patients should be seen by medical staff as soon as possible and if needed, admitted to the appropriate public facility. But the reality is that many patients sit for long periods of time without treatment being done until the next day or, when there is a vacancy in OR [Operating Room]. The clinical notes indicate that [Mrs A] was comfortable and her cares, such as repositioning, were all undertaken. Staff identified that pain relief may be required and on the PM shift she was found to be sleeping comfortably. Pain relief was offered and given the next morning.

2. Were the systems in place provided by [the Hospital] in managing a resident's hip dislocation appropriate?

In reviewing the information supplied, I believe that [the Hospital] has adequate systems in place.

What standards apply in this case?
All aged care hospitals must meet the Health and Disability Sector standards, NZS 8134.1:2001. [The Hospital] was an accredited facility which means that the audit process identified that [the Hospital] meets the standards applicable. I have viewed no evidence to indicate that [the Hospital] would not comply with these standards.

Registered Nurses in their own right must meet the Competencies for Entry to the Register of Comprehensive Nurses (amended 8th February 2002). Nursing Council of New Zealand governs the practice of Nurses and midwives by setting and monitoring standards of registration and enrolment which ensures safe and competent care for the public of New Zealand. There are 11 competencies which Registered Nurses must meet; they include:

- Communication;
- Cultural Safety;
- Professional Judgement;
- Management of Nursing Care;
- Management of the Environment;
- Legal Responsibility;
- Health Education;
- Inter-professional Health Care;
- Quality Improvement; and
- Professional development.

Were those standards complied with?
I believe that the relevant standards were complied with in relation to the care provided to [Mrs A].

Other Comments
I note that [the Hospital] is a 40 bed facility and on the date in question, there was one registered nurse with the overall responsibility for the hospital. She [Ms C] also had a patient load of 8. It is my opinion that, this allocation of a patient load and the overall responsibility of the facility is too much. The registered nurse is ultimately responsible for medication administration and all the assessment and care needs. I do not believe that one registered nurse should have a patient load as well as the other responsibilities that go with her job. A patient load of 8 hospital patients is in my opinion enough to keep one caregiver, or nurse, busy for a full 8 hours shift without the extra responsibilities of supervision and delegation of care to health care assistants and the management tasks required.

On call medical staff — It is my opinion that the system that was used at the time of the incidents was not adequate to identify which medical officer was on call. I have noted that [the Hospital] has made changes to rectify this with a better system."

Code of Health and Disability Services Consumers' Rights

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

Right 4

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

Opinion

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

No breach — Ms C

Mrs A dislocated her hip on the evening of 16 January 2006, and it remains unclear as to how this occurred. Although Mrs A had a documented history of such events, she had not previously dislocated her hip during her month of residence at the Hospital.

From the recording provided by Mrs A's family, it is evident that Mrs A's calls for assistance at approximately 7.30pm went unanswered for at least four minutes, and during this time it is probable that she was standing with her right hip dislocated. This undoubtedly would have been frightening and highly distressing, and it is unfortunate that her emergency bell was out of her reach. In addition, the first person who attended Mrs A, Ms F, apparently misunderstood her request for assistance, and believed she needed help to go to the toilet. However, it was soon recognised that she was experiencing difficulties with her hip.

Ms C, as the RN on duty during that shift, had overall clinical responsibility for the residents under her care, and responsibility for supervising the work of the HCAs on duty at that time. Ms C was at the nurses' station when she was informed by Ms E (at approximately 8.20pm) that there was a problem with Mrs A's right leg. Ms C went to Mrs A's room immediately.

Ms C stated that she visually assessed the position of Mrs A's legs as she lay flat on her bed, noting that the right leg was clearly shorter than the left and rotated. I am satisfied that her questioning of Mrs A was thorough and appropriate. She correctly assessed that based on her understanding of Mrs A's medical history, it was probable that Mrs A's right hip had dislocated. Ms C then ensured that Mrs A was comfortable, using pillows to support and immobilise the leg.

It is apparent that Ms C followed the Hospital's procedure for contacting medical services by telephoning Dr K, a call logged at 8.31pm. My expert nursing advisor, Ms Jan Featherston, advised me that it was appropriate for Ms C to telephone the on-call doctor and, on not reaching him directly, to leave a message for him asking that he return her call. However, the Hospital's system of informing staff of locum cover for medical staff was, as noted by Ms Featherston, inadequate. As a result, information was mislaid. Ms C was therefore unaware that Dr K was unavailable and a locum was covering for him. (I will comment on this later in my report.)

For the remainder of her shift, Ms C continued to monitor Mrs A, who slept. Before going off duty, Ms C left a telephone message for Ms B with information regarding her mother, and she left a further message for Dr K. Ms C provided the night shift RN (Ms

D) with a detailed handover of Mrs A's care. Ms D also checked on Mrs A, noted that she was sleeping, and ensured that Mrs A remained comfortable throughout the night.

The next morning, Ms B found her mother, on the point of transfer to hospital, looking 'ghastly', distressed and almost incoherent. However, after Mrs A's initial calls for help and Ms F's attendance, and the hip dislocation being identified, there is no other evidence to suggest that Mrs A was distressed during the remainder of the night. Ms Featherston advised:

> "The clinical notes indicate that [Mrs A] was comfortable and her cares, such as repositioning, were all undertaken. Staff identified that pain relief may be required and on the PM shift, she was found to be sleeping comfortably. Pain relief was offered and given the next morning."

Ms Northey expressed the view that once it was identified that Mrs A had dislocated her hip it would have been prudent to seek immediate medical review. However, Ms Featherston stated:

> "I believe that it was appropriate for [Mrs A] to stay at [the Hospital] overnight. The clinical notes indicate that she had a comfortable night, and this is also confirmed in Registered Nurse [Ms D's] statement … In an ideal world, patients should be seen by medical staff as soon as possible and if needed, admitted to the appropriate public facility. But the reality is that many patients sit for long periods of time without treatment being done until the next day or, when there is a vacancy in OR [Operating Room]. The clinical notes indicate that [Mrs A] was comfortable and her cares, such as repositioning, were all undertaken. Staff identified that pain relief may be required and on the PM shift she was found to be sleeping comfortably. Pain relief was offered and given the next morning.'

Ideally, Mrs A's hip dislocation would have been discussed with a doctor shortly after it occurred. However, in my opinion, Ms C took appropriate action in leaving a message for Dr K and ensuring that Mrs A remained comfortable. Ms C also took steps to advise Ms D of Mrs A's condition and ensure that her pain levels and comfort were monitored throughout the night shift. Furthermore, when Ms C returned to duty the following morning (17 January), and was informed that Dr K had locum cover, she immediately contacted Dr L. Ms C then followed Dr L's instructions and ordered an X-ray of Mrs A's hip. Once the X-ray confirmed the hip dislocation, Mrs A's transfer to public hospital was arranged.

I note that Dr L, who reviewed Mrs A on that morning, considers that the care of Mrs A's dislocated hip was managed in an appropriate manner. I accept Ms Featherston's advice that Ms C "carried out her duties in a satisfactory manner".

Accordingly, in my opinion, Ms C provided services of an appropriate standard to Mrs A and therefore did not breach the Code.

Breach — the Hospital

As a provider of health care services, the Hospital has a duty to comply with the Code. Under Right 4(1) of the Code, the Hospital has an obligation to provide services with reasonable care and skill, which includes ensuring that there are adequate systems in place to ensure that residents receive timely medical care when required.

Training of staff
The information I have indicates that one of the health care assistants who had responsibility for providing care to Mrs A on 16 January 2006 was not familiar with Mrs A's predisposition to hip dislocation, and initially misinterpreted her cries for help. It is apparent that the enrolled nurse and at least two HCAs discussed the position of Mrs A's leg and understood that she was experiencing a problem with being able to stand or walk at that time. It is clear that taking Mrs A to the toilet when her hip was dislocated was painful for her.

The Hospital accepts that its caregivers were not clearly informed about Mrs A's condition and her recurrent hip dislocations. It was only when the enrolled nurse arrived and noticed that there was a problem with the position of Mrs A's right leg that the registered nurse was called in to assess the situation. However, I note that this was almost 40 minutes after Mrs A's first recorded contact with a caregiver. The Hospital acknowledges that the role of the senior registered nurses, and their supervision of caregivers, was not clearly defined.

Mrs A clearly attempted to inform the caregivers of the problem she was experiencing, and this information was initially not heard or taken into account. As a result of this, Mrs A suffered added stress and pain when the attempt was made to walk her to the toilet with her dislocated hip. The Hospital had a responsibility to provide its staff with sufficient information for them to take the appropriate and timely action when they encountered a resident in distress.

Access to medical assistance
The Hospital has acknowledged that a note containing the information that Dr K was on leave, and providing the contact details of the locum, was taped to the "patient notes trolley" and apparently came loose and fell off. As noted by Ms Featherston, this method of documenting important medical contact information was clearly inadequate. The consequence of this error was that Ms C, the registered nurse for the evening shift on 16 January 2006 with overall clinical responsibility for the residents under her care, was compromised in her duties. Although she took timely and appropriate actions to seek medical assistance for Mrs A's hip dislocation, this did not actually occur until the following day.

Although Mrs A's treatment may not have been any different had she been seen by a doctor on the night of 16 January 2006, a doctor could have provided a considered opinion on the appropriate course of action, particularly as Mrs A had a history of hip

dislocations. I agree with my advisor, Ms Featherston, that the system used at the Hospital failed to identify which medical officer was on call for assistance.

Summary
In my opinion, the systems in place to ensure that Mrs A received adequate medical attention to manage her hip dislocation were clearly inadequate. Staff did not have sufficient information concerning Mrs A's history of hip dislocation, or what practical steps should be taken to manage such an event. The system for storing information about contacting medical services was poorly devised and maintained. As a consequence of these failures, there was a delay in staff bringing the matter to the attention of the registered nurse, and Mrs A was not seen by a doctor until the following morning (17 January 2006).

Accordingly, when Mrs A's hip dislocated on the evening of 16 January 2006, she was not provided with the appropriate medical attention in a timely manner. In my opinion, the Hospital's systems for ensuring residents received appropriate medical services when required were inadequate, and the Hospital therefore breached Right 4(1) of the Code.

Other comment

My advisor, Ms Featherston, raised the issue of the role of the registered nurse at the Hospital, and noted that:

> "[The Hospital] is a 40 bed facility and on the date in question, there was one registered nurse with the overall responsibility for the hospital. She [Ms C] also had a patient load of 8. It is my opinion that, this allocation of a patient load and the overall responsibility of the facility is too much. The registered nurse is ultimately responsible for medication administration and all the assessment and care needs. I do not believe that one registered nurse should have a patient load as well as the other responsibilities that go with her job. A patient load of 8 hospital patients is in my opinion enough to keep one caregiver, or nurse, busy for a full 8 hours shift without the extra responsibilities of supervision and delegation of care to health care assistants and the management tasks required."

I share this concern. It is apparent that, based on the information I have reviewed, this does not have a bearing on Ms C's care of Mrs A. However, in my view, it is a matter that the Hospital should consider when it reviews the role and job description of its registered nurses.

Actions taken

The Hospital has provided the Commissioner with two reports, dated 19 January and 18 April 2007, advising of the steps taken to improve and clarify its policies and procedures around managing the care of residents. Many of these changes were in response to the recommendations made by Robyn Northey in her report to this Office.

Guidance and training for staff
The Hospital has implemented a comprehensive ongoing training and in-service programme for its caregivers. The material covered in the programme is tailored to provide care staff with a better understanding of the requirements of the residents under their care and improve their work practice. The Hospital has continued to conduct regular performance appraisals for all of its staff. Following the internal investigation of the concerns raised by Mrs A's family, the relevant staff personnel files were updated to record the findings. The notations are part of the ongoing appraisal and training of these staff members.

The Hospital advised that there has always been an expectation that care staff would immediately contact the senior RN on duty should they encounter a resident in distress. Care staff have been advised and reminded of the importance of doing so expeditiously. Training has been provided to staff on conditions that are common to rest home residents, and all staff are being given more information about the condition of individual patients. The roles of both caregivers and nursing staff have been clarified.

The Hospital advised that, by the completion of their shift, RNs will have sighted each patient and completed a formal handover report to the incoming RN. The reports cover all patients. This means that the oncoming RN is informed about patients whose health status and/or behaviour is causing concern. The Hospital has reminded all staff of the requirement to write clear clinical records detailing the times and actions taken by specific staff to manage an event or incident.

On-call doctor information
The Hospital recognised that a handwritten record of its GP's contact details taped to the "patient notes trolley" was inadequate. In response to this event, the Hospital has instructed its senior staff to contact the nurse manager for clinical advice if the on-call GP is unavailable. The Hospital has also changed the manner in which it stores information about the availability of medical services. A hard copy is now kept in a plastic sleeve attached to the "records trolley", and this information is also passed on verbally during the shift handovers.

I am satisfied with the actions taken by the Hospital to improve its systems, its clarification of the care roles within its facility, and the ongoing training and monitoring of staff work practices.

The Hospital's apology has been forwarded to Mrs A's family.

Follow-up actions

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

- A copy of this report, with details identifying the parties removed, will be sent to HealthCare Providers NZ and Age Concern, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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