Registered Nurse, Ms C

A Rest Home

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC12434)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Complainant/consumer's daughter
Mrs B	Consumer
RN Ms C	Registered Nurse
Ms D	Facility Manager, the rest home
Ms E	Carer
Ms F	Carer
Ms G	Carer
Ms H	Independent investigator
Ms I	Carer
Ms J	Carer
The rest home	Provider/Rest home

Complaint

On 11 August 2006, the Commissioner received a complaint from a lawyer on behalf of Ms A, about the services provided to her mother Mrs B by a rest home. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs B by registered nurse (RN) Ms C between 11 and 13 November 2005.*

- *The adequacy of service provided to Mrs B by the rest home between 11 and 13 November 2005.*

An investigation was commenced on 27 October 2006.

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

Information reviewed

Information was obtained from:
- Ms A's lawyer
- Ms A
- Ms D
- Registered nurse, Ms C
- Ms E
- Ms I
- Ms J
- Ms F
- Mrs H, independent investigator
- The District Health Board

Independent expert advice obtained from Ms Jan Featherston, aged care nurse specialist.

Information gathered during investigation

Overview
Mrs B sustained severe injuries, including a fractured right neck of femur, left acetabulum, and left humerus while residing at a rest home. The injuries are believed to be the result of two unwitnessed falls sometime on 11 or 12 November 2005. As a result of the injuries, Mrs B required full assistance with personal cares and was unable to mobilise, requiring private hospital care. The lawyer for Mrs B's daughter, Ms A, stated:

> "[Mrs B] … is 84 years old and at the time material to this complaint had limited mobility. She is now completely bedridden."

Mrs B died the following year.

Background
Mrs B lived with her husband and primary caregiver, Mr B, in their own home. However, Mr B was terminally ill and became unable to care for her.[1] Mrs B was admitted to the rest home on 28 September 2005 for respite care. Ms A's lawyer advised:

[1] Mr B died a few months before his wife.

> "[T]he reason for [Mrs B's] admission to [the rest home] in the first place was because she was prone to injuries from frequent falls, requiring greater assistance than her sick husband was able to provide."

Mobility had been a longstanding issue for Mrs B. Her past medical history included osteoarthritis and chronic back pain. A support needs assessment,[2] carried out in January 2004, documented that Mrs B required assistance to mobilise. The assessment noted that Mrs B would generally use furniture for support when she was indoors. Her husband supported her when she was outside. The assessment also noted that, due to her chronic pain, Mrs B was able to sit or stand only for short periods of time. She found lying down most comfortable, and was reported to spend much of her time in bed. Mrs B was noted to have had falls in the past, requiring assistance to get up again. She was classified as a falls risk.

On 28 September 2005, upon admission to the rest home, an "initial assessment and short term care plan" was completed.[3] The plan documented that Mrs B was "very limited to ambulate — needs assistance". It also documented that Mrs B required assistance with some cares including grooming and dressing.

The admission falls risk assessment recorded Mrs B's mobility as category 4, meaning she required the assistance of another person to walk and was known to try to walk unaided. Overall, Mrs B was assessed as a medium falls risk.

Although the rest home progress notes initially documented Mrs B as requiring assistance to mobilise, on 29 September 2005 (the day after admission) she was recorded to be mobilising well. The progress notes stated:

> "Encouraged to walk to bathroom which she did with no trouble."

On 30 September 2005, Mrs B was reported in the progress notes to be mobilising independently to the toilet. The progress notes continue to document Mrs B as being independent with cares and mobilising independently to the toilet at night.

11 to 13 November 2005

On 11 November 2005, the progress notes record that Mrs B complained of back pain and was unable to sit up. Mrs B was also noted to be quite confused at times.

On 12 November 2005, it is documented in the progress notes that Mrs B went to the toilet independently. However, the carer, Ms F, who made this entry, later stated:

> "I hadn't actually seen her go, she was the only person in that Wing that did use that toilet at night."

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[2] Mrs B was assessed by an Assessment and Coordination Service.

[3] My advisor, Jan Featherston, sets out the initial assessment later in the report.

The rest home has acknowledged that the assumption that Mrs B used the toilet independently at night was inappropriate. Ms D, Facility Manager, stated:

> "Night staff did report that [Mrs B] had used the toilet during the night, however it was confirmed during the investigation that they did not actually witness this …"

On the morning of 12 November 2005, care staff, and cleaning and kitchen staff, observed that Mrs B was not herself. Concerns were expressed that Mrs B appeared pale and shaky. It is documented that Mrs B was complaining of back pain. On several occasions throughout the day Mrs B was found lying sideways across her bed. Each time she was assisted back into her bed. Care staff advised that RN Ms C, the registered nurse on duty, was made aware of these concerns. However, RN Ms C stated:

> "On the 12th October 2005 I arrived at work, handover was given but there was no report given of any changes in [Mrs B's] Health Status. When doing medications I saw [Mrs B] and noted a marked change since the last time I had seen her on the 9th October 2005. I questioned staff about this saying 'she looked like death warmed up' and did anyone notice any change in her condition, nobody could identify any reason for her altered health."

RN Ms C subsequently clarified that she was referring to 12 November and not October.

RN Ms C advised that the only observations by staff that she was made aware of were delusions and confusion. The progress notes document that Mrs B was feeling unwell and complaining of a sore back. It is also noted that Mrs B did not eat her lunch and remained in bed.

When caregiver Ms G entered Mrs B's room while delivering afternoon tea, she (again) found Mrs B lying across her bed. Ms G also noticed a strong smell of urine. Ms G asked carer Ms E and RN Ms C to assist in changing Mrs B. Ms G and RN Ms C assisted Mrs B to stand while Ms E went to get clean linen. While Mrs B was being assisted to stand, it became evident that she was unable to weight bear. RN Ms C explained:

> "Two carers notified me later that [Mrs B] was found lying across her bed, and she had been incontinent of urine on her bed. A moli-pad was put on her by one carer, and myself and another carer lifted her while this took place as it was apparent that [Mrs B] could not weight bear. One carer went to get a sheet, and myself and the other carer were still holding [Mrs B]. She was lowered gently to the floor by us both onto her knees by us both until the carer returned, the bed was changed and [Mrs B] was placed back on her bed, again she was not complaining of pain relevant to the fractures."

Ms E and Ms G also recalled Mrs B being unable to weight bear, as well as noting discolouration in her feet. Ms E explained:

> "Suddenly [Mrs B] collapsed and flopped down toward the bedroom floor. [RN Ms C] was holding her under the arms and stopped her from falling to the floor. Once [Mrs B] was back in bed I pointed out to [RN Ms C] that [Mrs B's] feet were discoloured (a purply red colour).[RN Ms C] gave no reaction to this comment."

RN Ms C advised that on observation Mrs B was "pale, sweaty and cool to the touch" but there was "no obvious heat, redness, or swelling to suggest trauma. The only thing that could be seen was a small blue bruise on her left humerus". RN Ms C also recalled that Mrs B was complaining of back pain.

RN Ms C believed that Mrs B's presentation related to her back pain, which she had complained of in the past. Therefore she considered it was appropriate to monitor Mrs B. As RN Ms C was the on-call nurse that evening she informed me that she instructed care staff to call her if there were any changes in Mrs B's condition. However, there is no documentation of her instructions. RN Ms C advised:

> "[Mrs B] had on several occasions in the past complained of severe back pain and remained bed bound. Usually this would last a day at most and she would be ambulating and back to her usual self. On the 12th November 2005, prior to her needing an incontinence product and bed change, [Mrs B] managed to manoeuvre herself to lying across the bed (width) way as opposed to lying full length of the bed as found and witnessed by myself and two caregivers.
>
> Because of all the above circumstances I believed that it was probable that [Mrs B] was again having another episode relating to her osteoporosis … It is with this reasoning that a Doctor was not notified on the 12th November 2005."

RN Ms C advised that she contacted both Ms A and Mr B, on the afternoon of 12 November 2005, to advise them of Mrs B's deterioration. At this time she also advised Ms A of a bruise she had noted on Mrs B's arm, assuring her that she would continue to monitor Mrs B's condition. This was not documented.

RN Ms C recalled that when Mr B visited Mrs B later that afternoon he was "tearful and upset". The nursing records document that Mr B had expressed concern about his wife's condition, as follows:

> "Husband visited in pm. Very concerned about his wife's condition. Full cares given. Moli-pad changed. Fed small amounts of tea. Refused to lie on her side because of sore back. Very sleepy & pale."

Further to this, a note in the progress notes by RN Ms C the following morning documented that Mrs B's daughter had telephoned following Mr B's visit. Mr B was concerned about bruises on Mrs B's arms.

Ms A does not recall anyone from the rest home contacting her about Mrs B. Similarly, there is no record on the rest home telephone account records of a telephone call being made to Ms A at this time. Ms A advised that she contacted the rest home after receiving a telephone call from Mr B. Mr B expressed concern that Mrs B was looking unwell. Ms A then contacted the rest home and was reassured that her mother was fine. Ms A is unsure which staff member she spoke to.

RN Ms C advised that when she returned for duty the following day, Sunday 13 November, Mrs B had not improved. RN Ms C continued to monitor Mrs B and advised that she contacted the on-call GP at approximately 11am. However, there is no record of any observations until 1.50pm and then again at 2.30pm.[4] The only record of the GP being contacted is in the same note as the above observations. It does not record what time this contact was made.

Ms D, Facility Manager for the rest home, recalled that RN Ms C contacted her to discuss Mrs B's condition on 13 November 2005. However, her recollection is that this conversation occurred at approximately 2pm. Following this telephone discussion, RN Ms C contacted an after-hours on-call GP service (the GP service).

Ms D advised:

> "[RN Ms C] telephoned me on Sunday 13 November 2005 at around 2pm and explained that [Mr B] had been in to see his wife and was worried about his wife's condition. [RN Ms C] also informed me that [Mrs B's] daughter has queried the bruising on her mother's arms.
>
> …
>
> [RN Ms C] also described [Mrs B's] condition to me as of poor colour and unable to weight bear. [RN Ms C] made no mention of [Mrs B's] injury being serious nor did she give me any indication that there was something seriously wrong with her.
>
> [RN Ms C] queried whether she should call a doctor or not. She indicated that she was making the query as [Mrs B's] family had requested her to do so.
>
> I advised [RN Ms C] to take a full set of nursing observations including pulse, temperature, respiration, and blood pressure. I also advised her to call the emergency doctor to visit [Mrs B]."

She pointed out that the timing of the recorded nursing observations suggests the call was on the Sunday afternoon.

[4] The observations recorded at 1.50pm were BP 130/80, pulse 90bpm, temperature 36.7°C, and at 2.30pm, BP 100/60, pulse 100, and temperature 36.5°C.

When RN Ms C called the GP service she initially spoke to a nurse. There is no record of what time the medical review request came in. However, the GP service advised that the nurse who took the call was rostered on between 7.45am and 2.45pm on 13 November 2005. Therefore the call must have come in sometime during this shift.

The on-call GP was subsequently sent to assess Mrs B. Following his assessment, the GP documented that Mrs B had deteriorated over the last two days and was unable to mobilise or assist with cares. He noted Mrs B to be "a bit pale" and decided to refer her to hospital for a medical opinion.

Ms A's recollection was that on Sunday 13 November, Mr B called her at approximately 10am still very concerned about his wife. Ms A then called the rest home to check how her mother was. Ms A was advised that Mrs B was fine and not to worry. Later that day, at approximately 3pm, Mr B again called Ms A, this time advising that Mrs B was lying askew on her bed in a singlet. Mr B also advised Ms A that Mrs B was sweating and looking very pale. Ms A again called the rest home and requested that someone check Mrs B while she remained on the telephone. The care staff member Ms A spoke to reported that Mrs B was just hot and reassured her that there was no need to worry.

Ms A advised:

> "On [the afternoon of 13 November 2005] at the insistence of visiting friends and my Dad, a Doctor was called to see Mum and an ambulance took her to [the nearest public] Hospital."

Hospital admission

Mrs B was admitted to hospital on the afternoon of 13 November 2005 at 3.51pm, and assessed by the medical house surgeon at approximately 4.30pm. The house surgeon documented that, on observation, Mrs B's right leg appeared shortened and externally rotated. Pain on passive movement was also noted. X-ray results indicated a fracture of the right intertrochanteric neck of femur and left acetabulum, with a central dislocation. Further X-rays revealed that Mrs B also had a fractured left humerus.

The cause and the nature of the fractures Mrs B sustained were of concern to the clinical staff at the hospital. The orthopaedic registrar who admitted Mrs B following the initial assessment in the Emergency Department, stated:

> "The fractures are severe and are consistent with significant trauma. It is possible to [mobilise with] one of the injuries to her pelvis, but usually an injury of this type will render a patient unable to weight bear and thus to be able to walk again and sustain an injury to the other side is unlikely (but not entirely impossible).
>
> …

> It is the number of significant injuries and the lack of knowledge of how [Mrs B] sustained these injuries that has caused the orthopedic team to have our social worker explore the rest home's care provision."

The hospital social worker contacted Ms D on 15 November 2005 seeking information regarding Mrs B's care. The social worker documented that when this matter was discussed with Ms D, she expressed concern in relation to the mechanism of Mrs B's injuries. Ms D also expressed her intention to investigate the matter further through an independent investigation.

Mrs B's right neck of femur was treated with a dynamic hip screw and plate on 16 November 2005. The fractures to her left acetabulum and humerus were both treated conservatively.

Mrs B's discharge to hospital care
Mrs B remained in hospital until 19 December 2005, when she was transferred to a private hospital. At the time of discharge, Mrs B required full assistance with her personal cares, and the assistance of two people to transfer from bed to chair.

The discharge letter written by a Consultant Physician documented that Mrs B was still experiencing significant pain and limited mobility. He stated:

> "[Mrs B] still has ongoing musculo-skeletal pain secondary to her fractures presumably aggravated by underlying arthritis and enforced bed-rest during conservative management of her arm and left pelvic fractures. She is currently on regular Paracetamol, [dihydrocodeine] and more recently Tramadol.
>
> She requires full nursing cares because of her immobility needing two to assist with transfers, has impaired cognition with low motivation and inability to attend to any self care activities including feeding …
>
> I agree that discharge to Hospital level nursing care is now appropriate."

As noted above, Mrs B subsequently died in 2006.

Response — rest home
Ms D advised that, owing to the seriousness of the situation, the rest home initiated an independent investigation to ensure a thorough and unbiased inquiry was carried out. Mrs H was asked to carry out the investigation. Ms D advised that Mrs H was chosen based on her "reputation as an investigator, and her proactive opposition to elder abuse".

Mrs H commenced her investigation on 15 November 2005. During the course of her investigation, Mrs H talked with hospital staff. She also obtained written statements from the orthopaedic registrar and a social worker. In addition, she conducted interviews with all care and other staff who were rostered on between 11 and

13 November 2005, gaining their accounts of the situation and the care provided to Mrs B.

Following the completion of her investigation, Mrs H considered two options in relation to Mrs B's injuries. Mrs H suggested that Mrs B could have fallen in the toilet area, managed to pull herself up and back to her room, then lost her balance and again managed to pull herself up and onto her bed. She thought this was possible. Mrs H also considered the possibility that Mrs B had a fall and was helped up by a staff member, but she thought this was doubtful. Mrs H concluded that Mrs B must have fallen twice, and this may have been during three hours of unaccounted time between 5pm and 8.30pm on Friday 11 November 2005.

Mrs H also concluded that there had been no abuse by staff members. However, she did consider that there had been neglect by senior staff in not identifying the problem sooner. Mrs H stated:

> "Bad habits and lack of good communication skills played a major part in this case. Lack of confidence in dealing with a situation showed up throughout the 3 days till [Mrs B] was admitted to hospital."

Mrs H made a number of recommendations including improved reporting and communication between staff.

Ms D agrees that it is possible that a staff member or members assisted Mrs B following a fall, but she has been unable to identify anyone or obtain any information about this. She also has acknowledged the lack of assessment by the registered nurse on duty. In response to Mrs H's finding, Ms D advised:

> "We acknowledge that there was a failure on the part of the Registered Nurse to adequately and appropriately assess [Mrs B] and make appropriate clinical interventions on 12th and 13th November 2005. … Disciplinary procedures were implemented in relation to this Registered Nurse as well as providing her with additional training and supervision."

Ms D has since clarified that following the completion of the independent investigation, a "counseling" session was held with RN Ms C. This took place on 30 November 2005. During this session, areas in which RN Ms C needed to improve were outlined and discussed with her. Ms D advised that this was initiated subsequent to the issues raised by Mrs H in her report, coupled with other performance concerns.

In addition to the action taken on RN Ms C, Ms D also advised that the rest home had provided education to staff in relation to clinical documentation requirements.

Additional information

RN Ms C no longer works at the rest home, and is not currently practising as a registered nurse.

Independent advice to Commissioner

The following expert advice was obtained from Jan Featherston, aged care nurse specialist:

> "I have been asked to provide an opinion to the Commissioner on case 06/12434. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I have read all the supporting information as listed.
>
> **Supporting Information:**
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> - Letter to the Commissioner from [Ms A's lawyer], together with attachments dated 11 August 2006 marked 'A' (pages 001–023).
> - Investigation letters to [the rest home company] and [RN Ms C] dated 27 October 2006 marked 'B' (pages 024–028).
> - Letter from Ms D, Facility Manager, [the rest home], together with relevant attachments dated 28 September 2006 marked 'C' (pages 029–067).
> - Letter from [Ms D] to the Commissioner dated 16 November 2006 marked 'D' (pages 068–069).
> - Copy of letter to the Commissioner from [RN Ms C] dated 24 November 2006 marked 'E' (pages 070–073).
> - Copy of letter to the Commissioner from [RN Ms C] dated 28 January 2007 marked 'F' (pages 074–076).
> - Letter to the Commissioner from [Ms E] dated 22 January 2007 marked 'G' (pages 077).
> - Letter to the Commissioner from [carer Ms I] dated 9 January 2007 marked 'H' (page 078).
> - Letter to the Commissioner from [carer Ms J] dated 10 January 2007 marked 'I' (page 079).
> - Email from [Ms F] dated 9 January 2007 marked 'J' (page 080).
> - Copy of [Mrs B's] clinical records from [the] District Health Board marked 'K' (pages 081–115).
> - Copy of [Mrs H's] interview transcripts marked 'L' (pages 116–133).
>
> **Background**
>
> [Mrs B] was admitted to [the rest home] on the 28th September 2005 for respite care as her husband was unwell.
>
> On the 11th November [Mrs B] become unwell complaining of a sore back. On the 13th November [Mrs B] was admitted to a public hospital with multiple fractures.

In your professional opinion were the services provided to [Mrs B] by [the rest home] and [RN Ms C] appropriate?

[The rest home]
[The rest home] carried out an initial assessment/short term care plan (Page 034–035).

This assessment identified the resident's name, date of birth, contact details for next of kin.

No base line recordings were entered on this sheet.

Further down the page 'activity of living items' are listed where staff were to write what the patient's perception/ability is and what staff intervention is to occur.

This form is completed as such:

	Patient's perception/ability	**Staff Intervention**
Hygiene	*Usually has a stand up wash*	*Washes what's visible*
Skin Integrity	*Intact*	*Good skin integrity*
Oral Hygiene	*Will maintain oral hygiene*	*Can brush teeth independently*
Dressing	*To maintain good grooming*	*Will need assistance with grooming*
Mobility	*To maintain some mobility*	*Very limited to ambulate needs assistance*
Elimination	*Can maintain good elimination*	*Needs assistance to toilet control*
Food /Fluids	*Good dietary intake*	*Needs encouragement*
Mental State	*Can be understood can be confused at times.*	*Verbalises well*
Communication	*Verbal skill good*	*Can be understood well*
Sensory	*Fading eyesight*	*Glasses needed at all times*
Sleep & Rest	*Usually sleeps quite well*	*Needs sleeping tablet to settle*
Individual routine	*Awake early has breakfast in bed*	*Needs to be helped with settling. Settles when ready*
Cultural Needs	*Likes to keep in touch with what's happening outside*	*Would like visits from outside groups*

There is a small area on the bottom of the sheet which has tick boxes, half of these are completed.

The assessment form/short term care plan is not signed. Nor is the designation of the person who completed this form.

The second area of assessment was the falls risk assessment — this form asks staff to document in the column where they think the patient is at in relation to fall risk.

Staff have assessed [Mrs B] as being 10 out of 21. This identified [Mrs B] as being the level of medium falls risk.

The clinical notes form the body of the resident's file (pages 0037–0044); also included are:

The resident medical information form and medical notes (pages 0045–0048).

Admission agreement and Contract (pages 0062–0065).

The initial assessment/short term care plan is brief. Parts of the assessment do not fully explain to staff what interventions in particular care staff would need to undertake, an example would be *'Hygiene'* the form is completed *'usually has a stand up wash'*. Staff intervention is listed as *'Washes what's visible'*. This does not give any indication to staff as how [Mrs B] can be assisted to meet her needs.

Within the mobility component it is listed as staff intervention *'Very limited to ambulate needs assistance'*. Again this does not state what assistance is required, whether a walker or stick is required or such assessment issues as how far [Mrs B] can walk. It does not state what may enhance or inhibit her mobility.

Elimination again identifies that [Mrs B] needs assistance but does not detail what assistance she needs, or what equipment may help her to be more independent eg, such things as a raised toilet seat or toilet frame.

I could find no evidence that the short term care plan was evaluated.

Baseline recordings are not done and I could not find anywhere except in the resident medical information form where a blood pressure and pulse are listed. Weight does not appear to have been taken on admission.

The progress notes are what are typically seen in aged care. The clinical notes are used by both registered nurses and caregivers. Generally care staff document what care they have completed on the different shifts, and registered nurses write when there are care issues such as UTI or deteriorating condition.

The initial entries show that [Mrs B] needed support while she was mobilizing. On her second day she was not able to walk and needed a commode in her room. [Mrs B] complained of back pain on several occasions.

The clinical notes state (difficult to read — the date I think is the 11th November) at the start of the PM shift [Mrs B] was happy chatting to the other residents and was independent with cares. Later on that shift the notes indicate that she complained of a bad back.

The night report states that [Mrs B] was 'Asleep on checks. Up to the toilet during the night'.

The next morning: The care staff state that [Mrs B] is feeling unwell complaining of a sore back she was not able to stand at this stage and this was noted by the staff on this shift.

PM: Visited by her husband, who was concerned about his wife's condition? Care staff have stated and documented that 'she was very sleepy and pale'.

Night: Caregivers have documented looks very pale talking well, aware of what's going on, asleep on checks. Little movement during the night.

AM: The entry is documented by [RN Ms C] who notes the concern from husband re bruising on [Mrs B's] arm. She also notes that [Mrs B's] condition is lethargic.

Later in the day 13.50 pm and 14.30pm she notes base line recordings.

My opinion is that the assessment process is poor and lacks substance. It does not outline good nursing and care interventions. There is limited information collected. One would expect to see a base line of recordings and weight recorded on admission. One would expect to see a thorough documentation of the resident's ability to carry out her activities of living as what helps or hinders this. There is no pain assessment and yet pain was a major part of [Mrs B's] problems.

It is my view that the lack of assessment would be viewed as [a mild departure from standards] by my peers.

Registered Nurse [RN Ms C]

[RN Ms C] was the registered nurse on duty of the mornings of the 12th November through till the 13th November. As the only registered nurse in the rest home it was her duty to provide care and supervision for the residents.

A registered nurse works within the scope of practice and is deemed to meet the Competencies for registration as published in the Nursing Council of New

Zealand standards. This ensures safe and competent care for the public of New Zealand. The Competencies were amended 8th February 2002.

The competencies outline 11 Criteria:

- Communication
- Cultural Safety
- Professional Judgment
- Management of Nursing Care
- Management of the Environment
- Legal Responsibility
- Ethical Accountability
- Health Education
- Interprofessional health Care
- Quality Improvement
- Professional Development

Within each of the Criteria are listed Generic Performance Criteria. It is my opinion that [RN Ms C] failed to meet these.

1. Communication

1.9 Communicates clearly, verbally, and/or in writing, when giving instructions about client care to enrolled nurses, health service assistants or clients family/carers.

[RN Ms C] failed to communicate to the care givers what action to take/what care to give [Mrs B] when they had reported to her that [Mrs B] was not well. This is also evident when on standing [Mrs B] up and realising that she was unable to weight bear, no clear instructions or documented action plan was put in place. It would have been appropriate at that time to undertake a full assessment and report her findings to the medical staff and document it in the progress notes what action needed to be done by care staff.

Communication with the family was undertaken but again this was not documented in the progress notes until the 13th November.

No incident form was completed following [Mrs B] collapsing with care staff nor the bruise on her arm. A written incident form should have been filled out, one was not viewed in the documentation presented.

4. Management of Nursing Care

4.3 Obtains, documents and communicates relevant client information.

4.5 Uses professional judgement including assessment skills to assess the client's health status and to administer prescribed medications and/or consult

with the prescribing practitioner and/or refer client to other health professionals.

4.12 Combines effective assessment and professional judgement in determining the needs of the client and the preparation and ability of the health service assistant or family/carers to perform the delegated activities in relation to assistance with care.

[RN Ms C] failed to carry out assessment and document such on the 12th of November. In her statement (pages 070–076) she said that she noticed changes when giving out the medications. She stated that she asked care staff and no one could identify any reason for her altered health. She states that [Mrs B] was pale and sweaty and cool to touch she says that she took her pulse rate and blood pressure but could not recall what they were at the time. She states that [Mrs B] did verbalise back pain but that she had complained about that on a number of occasions.

[RN Ms C] states that she notified [Mrs B's] daughter about her mother's condition but again did not document this in the progress notes.

[RN Ms C] should have documented her findings and carried out a thorough assessment.

This would have included a full set base line recordings. It should have alerted [RN Ms C] that something was wrong when [Mrs B] could not weight bear, and was found lying side on in the bed. Any resident who presents cool, pale and sweaty is generally very unwell and in my opinion medical staff should have been notified and a visit requested.

[RN Ms C] states that she advised care staff to call her should they have any concerns re[garding] [Mrs B] but again this was not documented.

On the 13th November [RN Ms C] called the medical officer who visited and subsequently [Mrs B] was admitted to hospital.

I am of the opinion that my peers would view [RN Ms C's] conduct as [a mild to moderate departure from acceptable standards].

Was it appropriate to allow [Mrs B] to mobilize independently?

There is conflicting documentation around [Mrs B's] mobility issues. The [Needs Assessor] carried out the assessment on the 16/1/2004.

In the mobility assessment she states that [Mrs B] has to lean on the furniture for support and that [Mrs B's] left arm is her walking stick holding on to things. She states that she can sit and stand for short periods only. Lying down

is most comfortable. She goes on to state that [Mrs B] finds it hard to get up, sometimes needs help to do so.

Her ability to get up after a fall — listed as 'would need help'.

The assessment goes on to state [Mrs B] has minimal exercise/movement tolerance due to chronic and extreme pain. Can only cope with short periods sitting and standing as a result is confined to her bed, where she's most comfortable for much of the time.

The nursing assessment on arrival at the rest home states that [Mrs B's] mobility is 'very limited to ambulate needs assistance'.

Yet the progress notes state that [Mrs B] was independent with her cares and many entries state that she was up to the toilet during the night.

An independent investigation was carried out by [Mrs H]. She makes note of the fact that care staff write in the notes that [Mrs B] toilets herself during the night. But in fact no staff have observed this occurring.

Taking all of the presented documentation into account I am of the opinion that it would have been unsafe for [Mrs B] to mobilize independently and that staff should have followed the documented care plan which states 'needs assistance'.

Again a more thorough assessment of [Mrs B's] ability to walk independently should have been done once she settled in [the rest home].

I am also of the strong belief that [Mrs B] would not have been able to assist herself to stand once she had had a fall and certainly not lift herself back to bed.

Were the actions taken following the external review appropriate?

I am of the opinion that the actions taken by [the rest home] were appropriate.

Should [the rest home] have taken any additional steps to ensure a similar incident doesn't happen again.

My advice here is that the facility should review its short term assessment and care plan.

A more through assessment would identify what care and support residents needed. I did not view any policies relating to how often reviews were undertaken. This policy should state 3–6 monthly or earlier when a resident's condition changes."

Response to Provisional Opinion

RN Ms C
In her response to my provisional opinion RN Ms C reiterated her assertion that she did contact both Ms A and Mr B on 12 November 2005 advising of Mrs B's deterioration. At this time she also advised Ms A of the bruise on Mrs B's arm, assuring her that she would continue to monitor Mrs B and keep her informed of her mother's condition.

RN Ms C advised that the reason she did not report that Mrs B was unable to weight bear when she helped to change her on 12 November 2005 was because she did not fall or collapse, rather she was unable to weight bear and was "lowered gently to the ground". Similarly, in relation to the bruise on Mrs B's arm, RN Ms C advised "… again no-one knew how she had acquired the bruise, so an incident form was not completed".

RN Ms C did acknowledge that there are areas of her nursing practice on which she needs to improve. RN Ms C stated:

> "[T]here are areas of my nursing practice that I may need to focus on (documentation, communication, and making the right choices about my nursing instincts). Correctly making choices about what is evident and plausible. I do not blame anyone for the events that have transpired, [the rest home] wishes to remain a good caring facility (which I believe they are) and [Ms A] and [Mr B] made a complaint because they cared about a loved one. This has been a harrowing experience for myself and no doubt [Ms A] and [Mr B] while he was still living. I wished no ill will on [Mrs B] and wished I could have told her this personally. I believe I have learnt a great deal from this unfortunate incident."

The rest home company
The rest home company has agreed with the statement made by my expert advisor, Jan Featherston, in relation to the poor assessment carried out on Mrs B's admission.

In addition to this, the rest home company advised:

> "Although by no means mitigating the findings of the investigation, we would like it taken into account that [Ms D] — Facility Manager, had only taken up the role of Facility Manager at [the rest home] some three weeks prior to the incident in question, and was still very much coming to terms with the facility and identifying areas for improvement in service delivery."

The rest home company has also provided evidence of additional quality improvement initiatives it has undertaken. These include:

— Updating the "Assessment, Care Planning and Review" and "Fall Assessment and Intervention" policies and procedures

— Updating the "Initial Assessment Careplan" template.

— Developing a basic clinical assessment and treatment guidelines booklet for caregivers.

— Evidence of a clinical records and careplan audit.

— Developing a careplanning and documentation inservice training package.

Ms A
Ms A reiterated her concern on behalf of her family about the care Mrs B received. Her main concerns relate to the fact that while staff noticed a deterioration in Mrs B's condition, they did nothing about it until the following day. Ms A also expressed concern about the way the rest home subsequently managed the situation.

Regarding the impact of these events, Ms A wrote:

> "… our terminally ill Father witnessed the events unfolded in subsequent days and tried to come to terms with doing 'the right thing by placing his wife in safe care'. He was not listened to by staff and made to feel powerless. He passed away [just a few] months after these events took place."

In conclusion, Ms A stated:

> "My Mother [Mrs B] was placed in [the rest home] as a temporary measure to keep her safe to give my Father [Mr B] respite care. She arrived as a Level 3 patient, was capable of walking to the dining room (albeit semi-aided) and left the rest home by ambulance with 2 broken hips and a broken arm requiring Level 5 care for the rest of her life."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

Other relevant standards

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

- 1.9 Communicates clearly, verbally, and/or in writing, when giving instructions about client care to enrolled nurses, health service assistants or client family/carers.

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

- 4.12 Combines effective assessment and professional judgement in determining the needs of the client and the preparation and ability of the health service assistance or family/carers to perform the delegated activities in relation to assistance with care.

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.

Opinion: Breach — RN Ms C

Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) Mrs B had the right to receive services of an appropriate standard. The standards that apply in this case are the 2002 Nursing Council of New Zealand standards.

RN Ms C was the only registered nurse on duty on 12 and 13 November 2005, and on call during the evening of 12 November 2005. Accordingly, it was her overall responsibility to provide nursing care to the residents and supervise care-giving staff. Around this time, Mrs B suffered at least one unrecorded fall, which led to a deterioration in her health status and subsequent hospital admission.

While it is unclear when a fall or falls occurred, Mrs B's condition appeared to be deteriorating on 12 November 2005. This was noted by many of the staff on duty that day. She was reported to be looking very pale and shaky, and complaining of back pain. The progress notes document that Mrs B was feeling unwell, was complaining of a sore back, did not eat her lunch, and stayed in bed. The care staff report that their

concerns were expressed to RN Ms C. In contrast, RN Ms C denies these concerns were reported. However, she does recall staff reporting that Mrs B was confused.

RN Ms C recalls observing a significant change in Mrs B's condition on 12 November 2005. She said it was not reported at the handover, but she noticed a marked change during the medication round. She stated:

> "I questioned staff about this saying 'she looked like death warmed up' and did anyone notice any change in her condition, nobody could identify any reason for her altered health."

On a number of occasions Mrs B was found lying across the width her bed. During the afternoon tea round one of the carers, Ms G, again found Mrs B lying sideways across her bed and noted that she had been incontinent of urine. Accordingly, staff (Ms G, another carer, Ms E, and RN Ms C) changed Mrs B and her bed. While her bed was being changed Mrs B apparently "slipped" when she was stood up. Care staff also raised concern about discolouration of Mrs B's feet. RN Ms C explained:

> "A moli-pad was put on her by one carer, and myself and another carer lifted her while this took place, as it was apparent that [Mrs B] could not weight bear. One carer went to get a sheet, and myself and the other carer were still holding [Mrs B]. She was lowered gently to the floor by us both onto her knees by us both until the carer returned, the bed was changed and [Mrs B] was placed back on her bed."

RN Ms C did not assess Mrs B. She stated that she instructed care staff to call her if there was any concern, but this was not documented.

Under Criterion 1.9 of the Nursing Council of New Zealand's *Competencies for registered nurse scope of practice*, a registered nurse must provide clear instructions about a client's care. Criterion 1.9 states:

> "Communicates clearly, verbally, and/or in writing, when giving instructions about client care to enrolled nurses, health service assistants or client's family/carers."

My independent expert advisor, Ms Jan Featherston, considered that RN Ms C failed to meet this criterion. She advised:

> "[RN Ms C] failed to communicate to the care givers what action to take/what care to give [Mrs B] … This is also evident when on standing [Mrs B] up and realizing that she was unable to weight bear, no clear instructions or documented action plan was put in place. It would have been appropriate at that time to undertake a full assessment and report her findings to the medical staff and document it in the progress notes what action needed to be done by care staff."

Ms Featherston also advised that a written incident form should have been completed in relation to this event and when the bruise was observed on Mrs B's arm. This was not done. The only reference to the bruise in the progress notes was recorded by RN Ms C the following day in relation to Mr B's concern. The records state:

> "[Mrs B's] daughter had apparently rung yesterday after [Mr B] had visited. He is concerned about bruises to her arms and believes the carers are responsible. Noted one bruise on her (L) [left] arm yesterday when doing cares"

In addition, reference to Mrs B "slipping" while being changed appears to have been entered later as an additional note. All staff, including RN Ms C, deny making this additional note.

RN Ms C agrees that there had been a clear deterioration in Mrs B's condition on 12 November 2005. However, a referral for medical assessment was not made until 13 November 2005. RN Ms C advised that her decision not to refer Mrs B earlier was based on the fact that Mrs B had previously complained of severe back pain. RN Ms C explained that this would normally last one day at most. RN Ms C considered that all of Mrs B's presenting signs (back pain and being unable to mobilise) were similar to those she had experienced in the past. It was with this reasoning that she did not consider it necessary to request an earlier medical review.

Criterion 4 of the Nursing Council of New Zealand's *Competencies for registered nurse scope of practice* requires a registered nurse to use professional judgement and assessment skills when determining the needs of a client and deciding to involve another health professional. Criterion 4.5 states:

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

Criterion 4.12 states:

> "Combines effective assessment and professional judgement in determining the needs of the client and the preparation and ability of the health service assistant or family/carers to perform the delegated activities in relation to assistance with care."

Ms Featherston considers that RN Ms C did not meet these criteria. She advised:

> "[RN Ms C] should have documented her findings and carried out a thorough assessment. This would have included a full set of base line recordings. It should have alerted [RN Ms C] that something was wrong when [Mrs B] could not weight bear, and was found lying side on in the bed. Any resident who presents cool, pale and sweaty is generally very unwell and in my opinion medical staff should have been notified and a visit requested."

Ms Featherston also considered that RN Ms C did not comply with Criterion 4.3 of the Nursing Council of New Zealand's *Competencies for registered nurse scope of practice*, which requires a registered nurse to obtain, document and communicate relevant client information.

RN Ms C advised that she contacted the family in relation to Mrs B's deterioration on 12 November 2005. However, nothing was documented in the progress notes until the afternoon of 13 November 2005. Furthermore, there is no record in the telephone accounts, and Ms A does not recall ever being contacted by RN Ms C. Ms A advised that when she contacted the rest home on 12 and 13 November for an update on Mrs B's condition, she was told that her mother was fine when this was clearly not the case. It is unclear to whom she spoke.

Conclusion
Mrs B had deteriorated markedly on 12 November 2005. The ultimate responsibility for her care on 12 and 13 November 2005 lay with RN Ms C as the only registered nurse on duty. Overall, I do not consider that RN Ms C took adequate steps to ensure that Mrs B received appropriate and timely care.

RN Ms C denied that staff advised her of Mrs B's deterioration on 12 November 2005. However, she was aware that Mrs B was complaining of back pain, and also stated that Mrs B was delirious. RN Ms C explained that she observed deterioration in Mrs B when doing the medication round. She was also present when it became evident that Mrs B could not weight bear. In my view, RN Ms C failed to comply with her professional responsibility to assess Mrs B and refer her for medical assessment. Any assessment that was carried out was very basic and not recorded until later in the afternoon. RN Ms C's explanation as to why she did not refer Mrs B for medical assessment is inadequate, particularly in the absence of any evidence to suggest that RN Ms C carried out any meaningful assessment of her own. There is also no evidence that appropriate instructions were issued to care staff.

RN Ms C has not convinced me that she understood the seriousness of the situation. The Manager, Ms D, advised me that the reason RN Ms C contacted her on 13 November to discuss the appropriateness of requesting a medical assessment was because concern had been expressed by the family. This is supported by Ms A, who also advised that she contacted the rest home three times between 12 and 13 November 2005 each time expressing concern relayed by her father.

Furthermore, that RN Ms C continues to state that she called Ms A to advise her of Mrs B's deterioration is particularly worrying given that I have now been provided with the rest home telephone billing records. These show that no call was made to Ms A from the rest home between 12 and 13 November 2005.

Overall, I consider that RN Ms C failed to comply with professional and ethical standards, and therefore breached Right 4(2) of the Code.

Opinion: Breach —The rest home

One of the primary reasons Mrs B was admitted to the rest home was because of her falls risk and her increased need for assistance. Similarly, the needs assessment carried out in January 2004 documented that she had limited mobility and exercise tolerance, requiring support inside and outside the house. Mrs B was assessed to be a falls risk.

Mrs B was admitted to the rest home on 28 September 2005. In accordance with the rest home's "admission assessment" policy an initial assessment was carried out. A short-term care plan was subsequently developed.

Ms Featherston considers that the short-term care plan was unsatisfactory. She advised:

> "The Initial Assessment/Short Term Care plan is brief. Parts of the assessment do not fully explain what interventions in particular care staff would need to undertake, an example would be '*Hygiene*' the form is completed '*usually has a stand up wa*sh'. Staff intervention is listed as '*Washes what's visible*'. This does not give any indication to staff as how [Mrs B] can be assisted to meet her needs.

In her opinion, Ms Featherston believes that the assessment process lacked substance and did not outline good nursing and care interventions. Ms Featherston stated:

> "One would expect to see a base line of recordings and weight recorded on admission. One would expect to see a thorough documentation of the resident's ability to carry out her activities of living as what helps or hinders this. There is no pain assessment and yet pain was a major part of [Mrs B's] problems. It is my view that the lack of assessment would be viewed as [a mild departure from standards] by my peers."

Notwithstanding this, the short-term care plan documented Mrs B's mobility as "very limited to ambulate, needs assistance". In addition, Mrs B was assessed as a medium falls risk.

The initial entry into the nursing records on this day states that Mrs B required assistance with most of her cares and was unsteady on her feet. However, on 30 September 2005, two days following admission, it is documented that Mrs B was mobilising independently to the toilet. Mrs B continued to be allowed to mobilise independently to the toilet at night. She was also noted to be independent with cares shortly prior to her fall. There is no evidence that her care plan was ever evaluated.

The rest home stated:

> "[We] would like to note that [Mrs B's] mobility had improved significantly since admission and this is verified from the numerous entries into her progress

> notes that she had been independent with her cares and was mobilizing independently to the bathroom. …
>
> There is no record to indicate that [Mrs B] ever used her call bell to summon assistance with mobilization to the bathroom, and we feel it is unreasonable to expect that the two night staff members could pre-empt her need to do so thereby providing assistance.
>
> Having established that [Mrs B] was independent with her mobility, and did not summon assistance from staff to mobilize, we do not believe that there was a failure on the part of [the rest home] staff in this matter."

However, Ms Featherston commented that Mrs B should not have been allowed to mobilise independently. She stated:

> "Taking all of the presented documentation into account I am of the opinion that it would have been unsafe for [Mrs B] to mobilize independently and that staff should have followed the documented care plan which states 'needs assistance'."

Ms Featherston noted that Mrs B would have been unlikely to have been able to stand following a fall, let alone lift herself back onto her bed. The orthopaedic registrar had a similar view. He stated:

> "The fractures are severe and are consistent with significant trauma. It is possible to [mobilise with] one of the injuries to her pelvis, but usually an injury of this type will render a patient unable to weight bear and thus to be able to walk again and sustain an injury to the other side is unlikely (but not entirely impossible)."

The rest home also accepts that it is unlikely that Mrs B would have been able to lift herself after sustaining such significant injuries. Ms D stated:

> "We concur there is a probability that a staff member or staff members assisted [Mrs B] following a fall. However, we have been unable to identify such a person or persons, and without their cooperation and willingness to communicate this information it is impossible to substantiate the events."

Conclusion

While it is unclear how Mrs B sustained her injuries, the nature of her injuries indicates that they were most likely caused as a result of two falls. Falls are an unfortunate reality in elderly care and often they are preventable. Steps can be taken to reduce the risk, and mobility and falls risk assessments play a critical role in this.

In this case, both a mobility assessment (included in the short-term care plan) and a falls risk assessment were carried out by staff in accordance with the rest home policy. However, staff did not comply with the findings, and Mrs B was allowed to mobilise independently, apparently after she demonstrated the ability to do so.

By way of explanation, the rest home stated that Mrs B's mobility improved significantly following her admission. However, the rest home have acknowledged that while staff documented in the progress notes events such as Mrs B mobilising to the toilet independently at night, this was never actually witnessed. I am unable to determine whether Mrs B did indeed go to the toilet unassisted. While Mrs B's mobility may have been safe at times, it appears that her condition fluctuated depending on her level of confusion and back pain. Most significantly, the alleged improvement in Mrs B's mobilisation should have been a trigger for a thorough reassessment of her initial care plan. This was not done. As highlighted in Mrs H's report, this was in part due to a lack of good communication, and is an indication of a systems failure.

Regardless of whether Mrs B used her call bell or not, I believe that the rest home should have ensured that a staff member was present while Mrs B mobilised — as stipulated by the care plan — or reassessed her and modified the care plan.

It is my opinion that the rest home failed to ensure that adequate care was provided to Mrs B, and breached Right 4(1) of the Code.

Other comment
On the information available, it is not possible to determine whether a staff member assisted Mrs B after a fall and did not report it. However, I note with great concern the comments of the orthopaedic registrar, and my expert advisor, Ms Featherston, about how difficult it would have been for Mrs B to put herself back to bed having sustained such significant injuries. Although Mrs H concluded that it was unlikely that this occurred, it has not been completely ruled out, and the rest home has clearly acknowledged the possibility. In the absence of any evidence one way or the other, I am left with some disquiet about the matter.

I also note that Ms A was reassured that her mother was fine when internally staff were reporting some concerns. This is unacceptable. In relation to both these matters, it is appropriate that the rest home has since provided education to staff about the importance of promptly and appropriately reporting all incidents (including falls), and has reminded staff of their obligations to openly and honestly respond to family concerns in a timely way.

Actions taken

In response to Mrs H's report, the rest home advised that a meeting took place to remind RN Ms C of her role and responsibilities. Subsequent to this, disciplinary action was taken.

The rest home has provided evidence of ongoing staff training and education in relation to clinical documentation requirements. It has also provided evidence that a documentation audit has been carried out.

In addition, the rest home has reviewed its policies for the development and review of short term care plans. It has also updated its short-term care plan template to assist staff to complete it with adequate detail.

Recommendations

RN Ms C

- I recommend that, should RN Ms C seek to return to nursing practice, a competence review be considered by the Nursing Council.

- RN Ms C should provide Ms A with a written apology. This should be sent to this Office to be forwarded to Ms A.

The rest home

- I recommend that the rest home provide Ms A with a written apology. This should be sent to this Office to be forwarded to Ms A.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand with a recommendation that it consider whether a competency review is warranted if RN Ms C seeks to return to nursing.

- A copy of this report will be sent to the Ministry of Health and the District Health Board.

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