A Rest Home

Registered Nurse, Ms B

A Report by the
Deputy Health and Disability Commissioner

(Case 09HDC01641)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A (aged 93 years) was a long-term resident at a rest home. She had a number of chronic health issues. This report considers the adequacy of the care provided to Mrs A by the rest home and Clinical Support Registered Nurse (CSRN) Ms B in the last weeks of Mrs A's life.

2. Over a period of three months in 2009 (Months 3–5), Mrs A had repeated problems with rectal bleeding, which led to her being admitted to hospital on two occasions. On the 21st of Month 6, 2009, Mrs A commenced treatment for a urinary tract infection. Her condition and function deteriorated. Her appetite was poor and at times she was noted to be more confused and/or restless. Between Month 1 and Month 6, 2009, Mrs A lost four kilograms in weight.

3. From the 21st of Month 6, Mrs A's son asked nursing staff on several occasions if he could speak to a doctor about his mother's condition, but these requests were not passed on to the doctors.

4. On the 27th of Month 6, Mrs A was seen by Dr C, who queried whether she had had a cerebrovascular accident or a trans-ischaemic attack.[1] The following day, she was reviewed by Dr D, who requested blood tests, and also advised that Mrs A's lithium and aspirin should be withheld for the time being. Over the next four days, Mrs A's condition continued to deteriorate. She was having difficulty swallowing, and her food and fluid intake was limited. She was noted to be restless and agitated at times.

5. On the 2nd of Month 7, Mrs A's family were concerned about her further deterioration and asked for her to be medically reviewed. They were advised that the rest home did not have after-hours medical cover and that Mrs A would need to go to hospital. Mrs A's daughter-in-law, a GP, did not consider it appropriate for Mrs A to go to hospital to receive palliative analgesia, and arranged for another doctor to visit and assess Mrs A. The doctor noted that she was agitated and dehydrated, and considered that she had had a mild stroke. He prescribed morphine and antipsychotic medication. The following day, Dr C reviewed Mrs A's condition and noted that it was now terminal. All medications were stopped, except morphine. Mrs A died later that night.

6. I find that there was a lack of care and skill in the service provided to Mrs A by the rest home, and that there were problems with communication between nurses, and between doctors and nurses. Accordingly, the rest home breached Rights 4(1)[2] and 4(5)[3] of the Code of Health and Disability Services Consumers' Rights (the Code).

7. Aspects of the service provided by CSRN Ms B could have been better. However, the extent to which her workload and available support impacted on her ability to provide services of an appropriate standard is unclear. Accordingly, I do not find that she breached the Code.

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[1] A cerebrovascular accident, or stroke, occurs when blood flow to the brain is interrupted. A trans-ischaemic attack is commonly known as a mini-stroke.
[2] Right 4(1) — Every consumer has the right to have services provided with reasonable care and skill.
[3] Right 4(5) — Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Investigation process

8. On 26 August 2009, the Commissioner received a complaint from Dr A about the medical care provided to her mother-in-law, Mrs A, while she was a resident at the rest home.

9. An investigation was commenced on 18 June 2010. The following issues were identified for investigation:

- *Whether the rest home provided Mrs A with reasonable care and treatment over a four-month period.*
- *Whether clinical support registered nurse Ms B provided Mrs A with reasonable care and treatment over a two-month period in 2009.*

10. The parties directly involved in the investigation were:

The rest home	Provider
Mrs A (dec)	Consumer
Mr A	Son
Dr A	Complainant/Daughter-in-law
Ms B	Clinical Support Registered Nurse
Dr C	General Practitioner
Dr D	General Practitioner
The medical service	General Practice
Ms E	Registered Nurse
Ms F	Care Manager
Ms G	Clinical Support Registered Nurse

Also mentioned in this report

Ms H	Health care assistant
Dr I	General practitioner
Ms J	Registered nurse
Ms K	Registered nurse
Ms L	Registered nurse
Ms M	Health care assistant
Ms N	Registered nurse
Ms O	Education Coordinator
Dr P	General Practitioner
Ms Q	Registered nurse
Dr R	General Practitioner
Ms S	Registered nurse
Mr T	Rest home chief executive

11. Independent expert advice was obtained from registered nurse Margaret O'Connor (**Appendix 1**).

12. Preliminary advice was obtained from HDC's in-house clinical advisor, Dr David Maplesden, and from Ms O'Connor, to assist with assessing the complaint prior to the start of the formal investigation.

13. In assessing this complaint, my Office reviewed the general practitioner care provided to Mrs A. Responses were sought from Dr D, Dr C, and the medical service contracted by the rest home to provide general practitioner care to residents. No issues warranting formal investigation were identified. Nonetheless, I consider that some aspects of the medical care and associated documentation departed from expected standards to a mild degree. These issues have been brought to the attention of the doctors.

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

Information gathered during investigation

Background facts

Mrs A

15. Mrs A (aged 93 years) had been a resident at the rest home since 1998. She had a number of health problems, including osteoarthritis,[4] diverticulitis,[5] bradycardia, sick sinus syndrome,[6] and a history of deep vein thrombosis[7] and pulmonary embolus.[8] The latter had been treated with warfarin, which led to complications from bleeding haemorrhoids. Mrs A also had a history of anxiety and depression, and was taking lithium.

16. On 14 November 2008, Mrs A signed an advance directive, specifying the level of medical intervention she wanted in the event of a deterioration in her health. She indicated that she did not wish to be resuscitated, and that the focus of any medical intervention should be to provide comfort. This was countersigned at the time by registered nurse (RN) Ms E, and by general practitioner Dr D in 2009.

The rest home

17. The rest home offers rest home care, dementia care and hospital-level care for 180 residents, and other accommodation for more independent residents. At the time of these events the rest home employed two CSRNs who were each responsible for overseeing the nursing care provided in three areas of 30 residents (ie, one CSRN for 90 residents). The CSRNs reported to a Care Manager, who was supported by a Clinical Co-ordinator. The rest home also employed a part-time Education Co-ordinator and a full-time Human Resources Executive, both of whom were registered nurses, and a Quality Co-ordinator.

18. Mrs A was resident in one of the three areas at the rest home providing hospital-level care. The area in which Mrs A resided was under the oversight of CSRN Ms B.

[4] A degenerative disease of joints resulting from wear of the articular cartilage, which may lead to secondary changes in the underlying bone.
[5] Inflammation of an abnormal pouch in the intestinal wall.
[6] A group of heart rhythm disorders. Mrs A had a pacemaker inserted in 1997.
[7] Obstruction of a vein by a blood clot, without preceding inflammation of the wall. It is most common within the deep veins of the calf of the leg.
[8] A blockage of the main artery of the lung or one of its branches by a substance that has travelled from elsewhere in the body through the bloodstream. Usually this is due to a blood clot from the deep veins in the legs.

General practitioner involvement

19. At the time of these events, a medical service provided two doctors, Dr D and Dr C, on a contractor basis to provide GP services to the rest home. Between them they visited five days a week and after hours as required. On weekday visits, the attending doctor carried out a number of regular reviews (with most residents being reviewed monthly), and attended to any residents with an acute need. A medical service doctor could be contacted to provide telephone advice, including conversations with relatives, outside their hours of attendance, including weekends and evenings up until 10pm. However, the medical service was not obliged to provide after-hours services.

Month 3–Month 4, 2009

20. On the first day of Month 3, 2009, health care assistant (HCA) Ms H recorded in the progress notes that Mrs A had had an episode of heavy rectal bleeding. This was noted again on the following two days. On the third day of Month 3, Mrs A's son, Mr A, expressed his concern, and the out-of-hours GP service was contacted. Dr I advised that Mrs A should go to hospital.

21. Mrs A was admitted to hospital. She underwent a colonoscopy and was referred for outpatient follow-up. She was discharged back to the rest home on the 11th day of Month 3. The progress notes show that over the next few days Mrs A had further bleeding, and that she was anxious about this.

22. Dr D reviewed Mrs A on 21st of Month 3. He noted:

> "Dilemma re warfarin — rectal bleeding [with history of] PE + DVT [pulmonary embolism and deep vein thrombosis].
>
> P [Plan]: Restart warfarin but do Hb [haemoglobin] level monthly on an ongoing basis."

23. On the 23rd of Month 3, RN Ms E telephoned Mr A at Mrs A's request, as she was anxious about her bleeding and the warfarin treatment. RN Ms E noted that she confirmed with Mr A the plan to monitor his mother's condition and warfarin levels, and that they would contact a doctor when needed.

24. Dr D reviewed Mrs A on the 5th day of Month 4. Her INR was 4.3.[9] Dr D requested that warfarin be withheld for two days, then restarted on 2mg, and that levels should be checked again in a week. On the 6th of Month 4, Mrs A attended her colorectal outpatient appointment, and underwent haemorrhoid banding. It is evident from the progress notes that Mrs A remained concerned and anxious about her bleeding throughout this time.

25. On the 16th of Month 4, 2009, Mrs A and Mr A met with RN Ms E for a scheduled review of Mrs A's care needs. They discussed a range of issues, including Mrs A's physical health, mobility, and dental treatment. RN Ms E noted that Mr A wished to be informed any time, day or night, if his mother's condition deteriorated. Mr A also signed an agreement regarding family involvement in the assessment, planning and evaluation of care. It was noted that the rest home could share information with family members except in the case of impaired decision-making, in which case permission

[9] INR is the ratio used to measure warfarin therapy. The normal range is 2.0–4.0.

would need to be sought from her enduring power of attorney (EPOA). An EPOA in relation to care and welfare had been signed by Mrs A in favour of Mr A, but this was not invoked as Mrs A remained competent and able to communicate her decisions.

26. There was a further document entitled "Advance Directive", which supported a greater level of intervention than indicated in the earlier (November 2008) directive, but still with comfort as the goal. The document was completed by RN Ms E and signed by Dr D on the 21st of Month 4, 2009. It indicated that the content had been discussed with Mr A. This document was not signed by Mrs A.

27. Mrs A's care plan was reviewed six-monthly. No changes were made to Mrs A's care plan after the 30th of Month 3, 2009. The "Planning Care" policy stated that the RN in each unit was responsible for maintaining care plans, and the RN job description required RNs to evaluate the effectiveness of the plan. The CSRN job description stated that the CSRN was responsible for updating the care plans and keeping them current.

28. At the end of Month 4, Mrs A's weight was 62.3kgs. This was the third consecutive month in which her weight had fallen.

Month 5–mid Month 6, 2009

29. Dr D reviewed Mrs A on the 4th day of Month 5, 2009. No concerns were noted. On the 9th of Month 5, Dr D was asked to review Mrs A owing to an episode of further bleeding. Mrs A was readmitted to hospital that day. Dr A, Mrs A's daughter-in-law, spoke with a doctor from the hospital about the decision to take Mrs A off warfarin, and the possible consequences of this. Mrs A was discharged back to the rest home on the 12th of Month 5. RN Ms E noted that Mrs A was no longer taking warfarin, and that the medical officer was to be notified of this.

30. Dr D reviewed Mrs A on the 25th of Month 5. He noted that she was no longer on warfarin. He also noted the result of her recent lithium level test and advised no change to her dosage at that time.

31. The progress notes show that over the next week, Mrs A continued to have some episodes of rectal bleeding. It was noted on some days that she was feeling weak and tired. This continued throughout the first two weeks of Month 6.

32. On the 14th of Month 6, an agency registered nurse noted that Mrs A appeared to be "slowly declining in strength, motivation and ability with ADLS [activities of daily living] over time". Two days later, another agency registered nurse, Ms J, noted:

> "C/o [Complained of] extreme tiredness and difficulty with swallowing. Choked on dinner. Quite wheezy. Afebrile.[10] Coughed and vomited large amounts of phlegm and undigested food. BP [Blood pressure] 120/70 P [Pulse] 88 R [Respirations] 26.[11] Given 2 puffs Ventolin with good effect."

[10] No fever.

[11] Normal measurements for the average healthy adult while resting are: blood pressure below 130/80mm/Hg; pulse 60–100 beats per minute; respirations 12–18 breaths per minute.

33. Entries in the clinical records by HCA Ms H, RN Ms K and RN Ms J on the 17th of Month 6 indicate that Mrs A was still feeling unwell, and that she was not eating or mobilising well.

34. There are no entries in Mrs A's clinical records for the 18th and 19th of Month 6.

20–26th of Month 6, 2009

35. On the 20th day of Month 6, 2009, RN Ms L noted in the "Manager's 24-hour Report" that Mrs A's status was causing concern: "Mrs A — ++ weak and disoriented." Just before midnight, Mrs A was found on the floor in her room. It was noted that she had a slight pain in her left knee on palpation, but she was able to complete normal rotations and could weight bear. No other injuries were noted. There is no record of an Accident/Incident report having been completed.

36. HCA Ms M informed CSRN Ms B about Mrs A's fall the following morning. There is no record of Mrs A's family being informed, and they confirmed that they were not. CSRN Ms B asked staff to get a urine specimen, check this with a dipstick and send it for laboratory testing. The dipstick indicated a urinary tract infection, and Dr D was asked to review Mrs A that afternoon. He prescribed a five-day course of nitrofurantoin, and Mrs A had her first dose that night.[12]

37. Mr A also visited his mother that afternoon. He found her weak and confused, and unable to get to the toilet independently (with a walking frame) as she had been doing previously. HCA Ms M recalls that Mr A asked if he could speak to the doctor, and that she passed this request on to RN Ms L, who contacted the other areas of the rest home in an effort to locate Dr D but was not able to do so. RN Ms L recalls that in the meantime, CSRN Ms B spoke to Mr A and explained why Dr D had prescribed the nitrofurantoin. RN Ms L understood that Mr A was satisfied with this information.

38. On the 22nd of Month 6, it was noted that Mrs A was eating and drinking well, she was showered, and there were no concerns. It was noted in the Manager's 24-hour Report that Mrs A was much better.

39. An agency nurse, RN Ms N, subsequently recalled that when she came on duty that morning, she observed that Mrs A appeared to have lost weight since she had seen her last, several weeks earlier.

40. Mr A recalls that he telephoned the rest home that day and asked a staff member if he could speak to the doctor looking after his mother. When he was told that a doctor was not available and could not be contacted, he asked if a message could be left for the doctor to call him back at his convenience. Mr A did not receive a call back from a doctor.[13]

41. Dr D recorded a routine review of Mrs A on the 23rd of Month 6. He noted that there was no further bleeding, her blood pressure was 120/70mmHg, her chest was clear

[12] It is not clear whether Dr D saw Mrs A on the 21st of Month 6, 2009 or whether he simply wrote a prescription for antibiotics on the basis of the dipstick test result. Dr D subsequently stated that urinary infections are commonly encountered in the elderly and "one often prescribes an antibiotic on the basis of a dipstick test". His entry in the progress notes indicated only that he had prescribed nitrofurantoin, although RN Ms L's entry indicated that Mrs A had been seen by the doctor.

[13] Dr D later advised that he was unaware that Mrs A's family wanted to speak with him.

and there were no abdominal problems. He subsequently stated that he recalls Mrs A being somewhat more withdrawn than usual, but that there was nothing to suggest any treatable pathology.

42. Later that morning, a health care assistant noted that Mrs A had not eaten her breakfast. At 9pm, RN Ms J noted that Mrs A's appetite was still poor. Mr A telephoned that evening and again asked when he could speak with the doctor. He was advised that Dr D was likely to be in the area between 2pm and 3pm the following day.

43. Records for the 24th of Month 6 show that Mrs A was still not eating well. Mr A arrived at the rest home at 2.30pm, hoping to speak with Dr D, but was told that he had already left. Nursing staff were unable to contact him in any of the other areas of the rest home. RN Ms J recalled in an account subsequently provided to the rest home that she had contacted the senior RN on call to voice her concern about Mrs A's condition, and to ask for her family to be contacted, as she appeared "lethargic and not well" and "depressed".[14]

44. There are no entries in the notes for the 25th of Month 6.

45. The HCA looking after Mrs A on the morning of the 26th of Month 6 noted that Mrs A was not feeling well, and was very restless. She had not eaten much breakfast. That night, RN Ms L noted that Mrs A was very confused, not stable on her feet, and was eating very little.

46. Mrs A's weight in Month 6 was 61.5kg, with the ward diary indicating that this was checked on the 26th of Month 6. This represented a 4kg weight loss over the previous five months.

47. The rest home's "Weighing Residents" policy attributed responsibility for the weighing of residents to the nurses, caregivers and dietitian. All residents were to be weighed on admission, at one- or three-monthly clinical reviews, or as otherwise directed by the Medical Officer. The procedure involved the staff member weighing a resident, recording the weight on a weight chart, and referring any "discrepancies" to the Medical Officer or the dietitian. Follow-up was required for residents with weight loss of 2kg or more within one month or 4kg or more over six months. The rest home explained further that in these circumstances, an Accident/Incident Form was completed to alert the CSRN, who then sent a referral to the dietitian. No Accident/Incident Form was completed for Mrs A at this time.

27th–31st of Month 6, 2009

48. On the 27th of Month 6, CSRN Ms B reviewed Mrs A. Mrs A had vomited, and appeared weak, tired, and dehydrated. She was not constipated. CSRN Ms B requested that Mrs A be given metoclopramide,[15] and that she be seen by a doctor that afternoon. Staff were asked to encourage oral fluids. CSRN Ms B subsequently stated that she asked for a fluid balance chart to be started. She did not document this request, but a follow-up entry by an unnamed RN noted that Mrs A had been given

[14] RN Ms J later stated that she recalled raising her concerns about Mrs A with either CSRN Ms B or Education Co-ordinator Ms O.
[15] Medication to relieve nausea and vomiting.

the metoclopramide and a fluid replacement drink, and that a fluid chart was in progress. The fluid balance charts were only partially completed over the next five days, until the 31st of Month 6, after which no further entries were made.

49. Dr C reviewed Mrs A that afternoon. He noted:

> "Has become confused unable to walk Lt [left] hand weakness. Legs difficult to assess. Plantars not possible.[16] ? TIA [trans-ischaemic attack] ? CVA [cerebrovascular accident]."

50. Dr C subsequently advised HDC that the imperative in situations such as this is to ensure that the person is comfortable, and that major new treatments or hospital admission are indicated in only a very few situations. He considered that Mrs A's symptoms at that time were being well managed. He stated that he did not order any new treatment or investigations, although Mrs A's medication chart indicates that she was started on regular low-dose aspirin.

51. Mr A visited again that evening. There is no record of him having been contacted in relation to Dr C's assessment earlier in the day.

52. The following day (the 28th of Month 6), Dr D reviewed Mrs A. He noted:

> "Remains confused. Latest lithium 1.9mmgl/l but this may not be toxic if taken less than 12 hours before dose.
> OE [On examination]: Alert
> Still has some orientation
> Bit dry
> Pulse 80 regular
> 36°
> BP 110/70
> Chest clear, few basal creps
> Abdo NAD [Abdomen No abnormalities detected]
> (L) hand weak, not paralysed.
> P [Plan]: Get bloods — may have bled
> Stop lithium for time being
> Withhold aspirin for a week in case recent possible CVA was haemorrhagic."

53. Dr D subsequently explained that he ordered a full blood count. Mrs A had a history of bleeding from haemorrhoids and, although there were no symptoms of bleeding at the time and she was no longer taking warfarin, he considered that a test for anaemia would be prudent.

54. On the 29th of Month 6, a health care assistant noted that Mrs A was unstable on her feet and unable to stand for very long, but comfortable and relaxed when she returned to bed after a shower. That night, RN Ms L recorded that Mrs A was very weak and tired, and could not swallow anything. She was unsettled and appeared to be in pain. She was given a paracetamol suppository, and it was noted that because of her

[16] A plantar reflex is a reflex obtained by stimulating the sole of the foot with a blunt object, used to assess neurological function.

swallowing difficulties, no medication was to be given orally. Mrs A was identified as one of two residents in that area of the rest home whose status was causing concern: "[Mrs A] — deteriorating. Ø [nil] food/fluid intake. Restless — panadol supps. [suppositories] given regularly."

55. The rest home's "Pain Management" policy set out protocols to be followed to assess, identify and manage pain. The policy indicated that the RN was responsible for assessing pain and initiating the pain management protocol. The Medical Officer was also responsible for assessing and managing pain. The policy did not specify the frequency of assessments or reviews, or the system for escalating concerns to senior staff.

56. RN Ms N reviewed Mrs A the next morning, and noted that her difficulties with feeding might be due to an oral abscess. RN Ms N left a written message in the ward diary for Mrs A's mouth to be assessed, and for advice on an appropriate care plan. She also documented this in the progress notes. RN Ms N subsequently advised that she had left the written note after several calls to try to locate a CSRN, and having eventually learned that all of the senior nursing staff were in a meeting. CSRN Ms B did not see the diary entry or the progress notes, as it was CSRN practice at that time to rely on a verbal handover from the RN.

57. That evening, RN Ms J noted that Mrs A's condition was continuing to deteriorate, her communication was poor, and she had had only a few spoonfuls of Fortisip. It was noted that her son was being kept updated. RN Ms J saw Mrs A again at 9pm. RN Ms J noted on the Manager's 24-hour Report: "[Mrs A] — Difficulty swallowing. Marked speech impairment. Limbs cold. Very unwell."

58. Education Co-ordinator Ms O subsequently recalled that on the 30th or 31st of Month 6, she walked past Mrs A's room and noted her decline, and that she commented on this to CSRN Ms B. Ms O noted that staff had commented to her throughout the week about Mrs A being unwell, and that she had reinforced with them the importance of pressure area care and of informing the family and CSRN Ms B of any changes.

59. CSRN Ms B recalls that on the 31st of Month 6, as she walked past Mrs A's room, she noticed that Mrs A was coughing and quite distressed. She assessed Mrs A's swallow, and determined that she needed a puréed diet and thickened fluids. This was noted in the ward diary, and a sign was put above Mrs A's bed. CSRN Ms B discussed the change of diet with Mr A, who was visiting at the time. RN Ms J noted that evening that Mrs A was still having difficulty swallowing, and that she had choked on the thickened fluids. RN Ms J recalls contacting a senior nurse with her concerns on the 31st of Month 6.

60. At around 2pm that day, Mr A attempted to speak with a doctor seated at the nurses' station. He recalls that the doctor reluctantly admitted he was "one of the doctors" but was not interested in talking to him about his mother. Mr A recalls that a nurse intervened, and explained that Mrs A was unwell, and not able to swallow food or fluids without choking. Mr A thinks that it was also on this visit that a nurse or nursing assistant said, "Of course, she probably had a stroke a few days ago," which surprised him.

61. The doctor to whom Mr A spoke was Dr P, who is also contracted to provide GP services to residents at the rest home, but does not work for the medical service. Dr P recalls being spoken to by a member of the public, but notes that he may have seemed vague as he had no knowledge of Mrs A. Dr P states that a member of the nursing staff came up and "indicated that the patient was in a palliative care/terminal care situation and was being managed". Dr P further stated: "Whatever else was said must have satisfied me that things were ok and I left, leaving the nurse with the relative."

62. The rest home subsequently advised that CSRN Ms B recalled an occasion when a family member approached Dr P, who was "somewhat dismissive". She intervened and spoke with the family member, and understood that he was happy with the information given. She does not recall Mr A indicating that he still wished to see a doctor.

1st–3rd of Month 7, 2009

63. The HCA looking after Mrs A during the morning shift on the 1st of Month 7, 2009 (a weekend) noted that she had refused the thickened fluids. Her personal care was attended to, including mouth care, and it was recorded that she was being turned from side to side.

64. An agency registered nurse reviewed Mrs A that afternoon and recorded that she was opening her eyes spontaneously, and smiling and nodding appropriately in response to simple questions. She was eating only a few mouthfuls. She was peripherally warm. Mouth care was given.

65. RN Ms Q reviewed Mrs A overnight, noting that she was having sips of water only, was agitated at times, and "? in pain". Panadol was given. RN Ms Q recorded a request for a doctor's review the next day, with a view to charting intravenous or subcutaneous medication.

66. On the 2nd of Month 7, both an HCA and RN Ms Q noted in the early afternoon that Mrs A was agitated. She was refusing fluids, but given PR Panadol.

67. Mr and Dr A were with Mrs A for most of that afternoon. Dr A recalls that her mother-in-law was in a distressed state, unable to coherently vocalise, agitated, apparently physically uncomfortable, but still clearly alert, recognising them and responding with her eyes and hands. Dr A considered that Mrs A was obviously dehydrated.

68. When Dr A learned that the only analgesia charted was paracetamol as required, she asked about further medical assessment, and was told that Mrs A would have to go to hospital, as there was no medical cover available from Friday afternoon until Monday morning. RN Ms L was on duty that afternoon, and subsequently confirmed that it was her understanding at that time that there was no medical cover available at weekends. She refers to an internal memo regarding the after-hours GP care, noting that this did not state that GPs could be contacted by telephone.[17]

[17] It appears that Ms L was referring to a memo specifically in relation to resuscitation orders. This memo states: "As you are all aware — as from today ([Month 4, 2009]) [the medical service is] no longer in operation & there is no after hours, or weekend medical service."

69. The rest home subsequently provided HDC with further information in relation to the provision of after-hours medical care for its residents. It confirmed that at the time of these events it had been having difficulty securing after-hours (ie, weekday nights and weekends) medical cover. It outlined the background to this, and the changes that had occurred in the previous months. There had been a roster of doctors attending residents, but there were a number of changes which reduced their availability for after-hours cover. In Month 4, 2009, the medical service that had been providing services to the rest home, including after-hours services, advised that it was reducing the scope of its service and would no longer be able to provide after-hours visits, effective from the 15th of Month 4. The medical service continued to maintain its 24-hour call centre.

70. The rest home notified the District Health Board that it was working to resolve the issue, but that in the meantime, residents needing medical assessment after hours would need to be transferred to hospital by ambulance. The rest home also advised residents and their families or contact people of this situation, in a letter dated the 18th of Month 4, 2009. The rest home has provided HDC with copies of correspondence detailing its efforts to secure 24-hour medical cover over the following weeks.

71. The doctors' rosters are posted on a board in each house, and these include information about the availability of after-hours medical cover and GP contact details. The roster at this time stated that between 5pm and 8am "[t]here is no after hours or weekend service but the rest home doctors can be reached by phone for consults". Below that it stated that the medical service doctors could be contacted by telephone up until 10pm.

72. Dr A did not consider it appropriate for her mother-in-law to be taken by ambulance to hospital to obtain palliative analgesia. She contacted the medical service to request an urgent visit by an on-call doctor.

73. At 6.30pm on the 2nd day of Month 7, RN Ms L noted:

> "Resident +++ unsettled and calling out. Tolerating sips of thickened water and a puréed diet. Has had mashed potatoes and gravy at tea time. Washed, changed and settled to bed. However, still not settled and still calling out. Family has organised [on-call] doctor to come and review resident as family is not happy to wait for a Dr till tomorrow."

74. Dr A says that she can unequivocally state that Mrs A had only limited swallowing (with some choking) from Friday. They were present at evening meal time, and Mrs A ate no food. She had observable dry mucous membranes, lips and skin.

75. Dr R reviewed Mrs A at 8.40pm. He assessed her as dehydrated, very agitated, and as having had a mild stroke with right-sided weakness. Dr R was advised that Mrs A was not swallowing her medication. He prescribed 8mg of morphine sulphate subcutaneously, and then 0.5mg of risperidone each night, with advice to "push fluids". He noted that she should be medically reviewed the following day. Dr A states that it was very clear from her conversations with Dr R that he was quite aware that Mrs A was in decline or terminally ill.

76. Progress notes show that Mrs A had sips of water while awake that evening, and that she was settled overnight and appeared comfortable.

77. Dr C reviewed Mrs A the next morning. He noted: "Deteriorating. Stop meds. Condition now terminal. Morphine charted."

78. An entry in the progress notes by RN Ms S indicates that she informed Mrs A's family of Mrs A's poor prognosis.

79. CSRN Ms B noted at 10.25am that she had inserted an Insuflon into Mrs A's abdomen for subcutaneous medication, and that she had informed Mrs A's sister of her poor condition. Mrs A's sister was a resident in another part of the rest home.

80. Dr C subsequently noted his understanding that CSRN Ms B had been in touch with family and informed them of Mrs A's poor prognosis. CSRN Ms B states that the RN on duty that morning (RN Ms S) told her about Dr C's assessment of Mrs A's condition and prognosis, and that family had been informed. CSRN Ms B was unaware that Dr C had not spoken to Mrs A's family himself.

81. Mrs A died at 7.40pm that night, with her family present.

Subsequent events

82. On the 23rd of Month 7, 2009, Dr A submitted a complaint to the rest home. This was copied to HDC and to HealthCERT, the auditing and licensing arm of the Ministry of Health.

83. The rest home requested written statements from several of its staff, and from agency nursing staff, outlining their involvement in Mrs A's care, and seeking explanations for particular actions (eg, in relation to documentation of care provided and reporting concerns to senior staff).

84. On the 10th of Month 8, Care Manager Ms F wrote to Dr A, acknowledging that family requests to speak with a doctor were inappropriately managed by the rest home staff. The rest home apologised, and noted steps taken to remedy this. Ms F noted that the problems that arose were the result of individual failings by some staff, rather than a systemic failure. Ms F also noted that medical and nursing staff did not consider Mrs A to be in a terminal stage in the days preceding her death. Ms F offered to meet with Dr A to discuss this further.

85. On the 24th of Month 8, Mr and Dr A met with Ms F and the rest home's chief executive at the time, Mr T. Mr T reiterated the rest home's apologies for shortcomings in its service. The notes from this meeting show that Dr A said that in their view, the nursing care provided to Mrs A had been superb, but they were concerned about the medical care. They discussed a range of issues in relation to the care provided to Mrs A, including:

- the availability of medical care out of hours;
- the fact that the family did not know who Mrs A's doctor was, and had no direct contact with the doctor/s;
- whether nursing staff had the authority and/or confidence to contact a doctor when needed; and

- actions taken by the rest home to improve communications and systems since these events.

86. Dr D advised that he wrote to Dr A on the 30th of Month 8, 2009, offering to meet with her to address her complaint, but that Dr A declined.

Ministry of Health

87. HealthCERT requested a response to Dr A's complaint, and the HealthCERT Team Leader discussed the concerns raised with the DHB Planning and Funding Manager. HealthCERT wrote to Dr A on the 29th of Month 8, 2009, noting that while her complaint had been substantiated, HealthCERT was satisfied that the rest home had taken appropriate actions. HealthCERT noted that the corrective actions taken would be verified at the time of the next audit,[18] and that the DHB would be following up with the rest home to ensure that its arrangements for after-hours medical cover were in accordance with its contract with the DHB.

Further information from the rest home

88. The rest home provided information to HDC in response to Dr A's complaint, Dr Maplesden's preliminary clinical advice, and Margaret O'Connor's preliminary expert nursing advice. This information has been incorporated above, and the following points are also noted.

Communication

89. The rest home explained that the RNs state that they reported Mrs A's deteriorating condition, and the family's wish to meet with a doctor, to both of the CSRNs, but that the CSRNs deny this. The rest home stated that it has been difficult to establish exactly what happened in relation to the facilitation of meetings between Mrs A's family and a doctor, but that nursing staff maintain that they communicated regularly with Mrs A's family. A number of changes have been made to tighten up communication processes.

90. In her preliminary advice, Ms O'Connor noted that, in her experience, medical staff rely on nursing staff to prompt them to speak with significant others about future care. The rest home stated that contrary to Ms O'Connor's advice, it is their experience, generally, that nursing staff are likely to be reluctant to "prompt" medical staff to implement particular plans or take actions. It stated further that it had reflected on Dr A's observations that nurses appear to be intimidated by doctors, and considered how it might improve communication between them. The rest home subsequently sought the assistance of a member of its Board, also a doctor. On his advice, a meeting was held between the doctors, the rest home senior management, and the CSRNs to reinforce the need for collegiality and communication. The rest home noted that the CSRNs have always been instructed to attend all doctors' rounds with the RNs.

91. The rest home noted that all bureau staff are provided with a two-page memo explaining how to contact senior staff. It stated that the pager system is simple to use and all staff can contact a pager from any phone.

[18] The rest home was audited in 2010. The audit identified some minor shortfalls with regard to the continuum of service delivery and the provision of a safe and appropriate environment, but no major deficiencies.

Changes in condition

92. The rest home considers that it has sound protocols in place for reporting and responding to changes in condition. It noted that it is relevant that Mrs A was for comfort cares only, and that different protocols apply for patients who require active treatment and investigation.

93. The rest home noted that vital signs are checked when a resident is first admitted, and then only on instructions from doctors or senior staff. No such instruction was documented for Mrs A.

Staffing

94. At the time of these events, CSRN Ms B worked Monday to Friday, while CSRN Ms G worked Monday to Wednesday, and Friday and Sunday afternoons. The rest home stated that because CSRN Ms G's hours had changed, Education Co-ordinator RN Ms O was asked to work Thursdays and Fridays as the second CSRN. RN Ms O worked Mondays to Wednesdays as the Education Co-ordinator.

95. The Admissions Co-ordinator was on leave from the 13th to the 30th of Month 6, 2009, during which time RN Ms O assisted with some of her responsibilities. However, the rest home stated that the demands on her time for these tasks were of "low intensity". The Clinical Co-ordinator was on leave at the time of the events leading to this complaint. The permanent RN for the area of the rest home in which Mrs A resided was also on leave during the relevant time, and agency RNs were used to cover her role.

96. The rest home accepts its responsibilities in relation to staff training and orientation, but noted the particular challenges faced by aged care facilities in recruiting and retaining staff. It noted that it employs a full-time human resources executive as part of its efforts to maintain staffing levels.

97. The rest home provided HDC with further information in relation to its staffing levels and supervision arrangements. It noted the processes it has in place to deal with any staff performance issues, and that it employs an Education Co-ordinator. It acknowledges that there have been challenges with some of the more recently trained nurses, and stated that in response, new CSRN positions were introduced to ensure more rigorous oversight of practice.

Changes made

98. The rest home outlined the action it had taken and the changes that have been made since and/or in response to this complaint and investigation. These include:

- a number of changes to the staff structure. The rest home initially advised that it had appointed a third CSRN and disestablished the Clinical Co-ordinator position. It has more recently advised that there was a complete restructuring in October/November 2011. The Care Manager position has been disestablished, and there are now two Clinical Managers. There are five CSRNs, each of whom has oversight of a smaller area within the facility;
- the Education Co-ordinator position was increased to full time (and is now the Clinical Training Co-ordinator). The Clinical Training Co-ordinator's responsibilities include ensuring all staff are compliant with mandatory

training requirements, and managing staff attendance at external education programmes;

- the Quality Co-ordinator role has been disestablished and a Quality Risk & Audit Manager role introduced. The Quality Risk and Audit Manager is responsible for reviewing policy, procedures and risk management on an ongoing basis, to identify areas for improvement;
- changes made to documentation requirements to improve communication between staff (eg, introduction of a "Communication Log" and changes made to CSRN "Handover Sheet"). Staff are required to sign the Communication Log to acknowledge they have seen the instruction or request;
- changes made to arrangements for meetings between senior staff to improve communication (eg, early morning meetings initiated between senior staff to ensure regular updates on new or outstanding issues, and Continuous Quality Improvement meetings are now weekly instead of fortnightly);
- a review of the Pain Management policy and the introduction of more comprehensive pain assessment protocols;
- changes in documentation requirements. The rest home states that at the time of these events, there was a requirement for one entry to be made in the progress notes every 24 hours and by exception. These were usually made by the HCAs. In addition, an RN was required to record in the notes twice a week and by exception. The rest home has reviewed its policy in this regard and now requires the RN on duty in the morning to write in the notes daily, and the RN on duty in the afternoon and evening to write by exception only;
- a review of the care plan format. The rest home acknowledges that the previous care plan did not encourage critical thinking, and states: "The new Care Plan will involve more identification and assessment skills to identify needs/problems and to challenge staff to utilize realistic goals and interventions. The evaluation will also require much more thinking and involvement of others e.g. family, allied, nursing, and medical staff, instead of robotic wording, mandatory signature and tick boxes of the existing ones";
- a separate section in the resident's file for doctors' notes has been introduced, to improve accessibility and readability;
- changes to ensure all nursing staff are aware of doctor availability out of hours; and
- changes to ensure the rest home retains a record of all residents that doctors have been asked to see on any given day.

99. The rest home also confirmed that if a family member makes a non-urgent request out of hours to speak to a doctor, the request is recorded in the progress notes and the ward diary. It is ultimately the CSRN's responsibility to ensure that this is acted upon. The rest home provided further details of the information given to residents and their families about the availability of GP services and how these are accessed.

100. Dr D confirmed that, at the time of these events, both he and Dr C could be contacted up until 10pm daily for telephone advice, drug orders and discussions with relatives, and that he could be contacted for telephone advice after 10pm, provided the request had been approved by the rest home duty manager. The rest home subsequently advised HDC that it had entered into a contract with another medical service to provide after-hours medical care. The rosters have been amended to reflect the changes to doctors' availability. More recently, the rest home advised that its

contracting arrangement has been extended to provide for additional rostered hours as well as increased access to after-hours support.

101. The rest home also advised that in Month 8, 2009, it adopted the Liverpool Care Pathway for managing the care of people in the last few hours or days of their lives.

102. In October 2011, the rest home advised that it had had nil turnover for its enrolled nurses and registered nurses in the previous year, ensuring a "knowledgeable and confident workforce".

Further information from Ms B

103. CSRN Ms B provided HDC with information in relation to her previous experience, her orientation at the rest home in Month 1, 2009, and her responsibilities as one of two CSRNs overseeing the nursing care provided to 180 residents. She noted that while the CSRNs had an overall responsibility for the hospital areas, they "expected the RNs in those areas to be able to use the nursing process to implement any interventions, evaluate outcomes and update care plans as required … which is a fundamental and basic requirement of any registered nurse in NZ … and to keep family members informed and updated as per their job description at that time …".

104. CSRN Ms B stated that she did not consider Mrs A to be dying until the 3rd of Month 7, 2009 and, up until that time, although she was unwell, she was unwell from conditions that could potentially have been reversible or at least treatable.

105. CSRN Ms B recalls speaking with family on two occasions during the last week of Month 6, and said that on both occasions the man to whom she spoke (Mr A) seemed satisfied with the information provided and did not ask to speak to a doctor. She recalls being told on the 3rd of Month 7 by the RN on duty in the ward that morning that the doctor had seen Mrs A and considered her condition terminal, and that the family had been informed of this. RN Ms B then informed Mrs A's sister, but was not aware that the doctor had not spoken to her family.

106. CSRN Ms B also noted that on the 29th of Month 6, 2009 there was an outbreak of vomiting and diarrhoea at the rest home, which was subsequently confirmed to be norovirus. Consequently, she was particularly busy isolating affected residents and staff, notifying families, ensuring that affected residents were receiving appropriate care, and ensuring that adequate isolation precautions and safety measures were in place. CSRN Ms B stated that she was the only CSRN available on the 30th of Month 6 and up until 3pm on the 31st of Month 6. Nevertheless, CSRN Ms B stated that she was always available by telephone or pager if needed.

107. CSRN Ms B noted that she did not become aware of Mrs A's mouth abscess until the 3rd of Month 7, as at that time it was their practice to rely on staff verbally communicating concerns when they visited the wards each morning. She was not aware of Mrs A's weight loss. She noted that weights are usually checked at the end of each month, and stated that the RNs may not have had time to report this before Mrs A's death.

108. CSRN Ms B noted the changes that have been implemented at the rest home in relation to staff reporting. She advised HDC that following Dr A's complaint, the rest home had introduced a specific requirement for the CSRNs to read patient notes.

The rest home's response to first provisional opinion

109. In response to my first provisional report, the rest home stated that it does not consider the failures and deficiencies of its nursing staff were impacted or caused by systemic issues, and it does not consider it fair to attribute overall responsibility for these failures to the rest home. The rest home submitted that it provides a supportive and collegial environment, where there is a wealth of experience and expertise at any time, along with comprehensive policies and procedures.

110. The rest home submitted that it was entitled to expect all RNs in its employment to perform their duties in accordance with the professional standards and responsibilities incumbent on nurses.

111. The rest home stated that its recruitment, orientation, training and appraisal processes are robust, and that it does not accept that it failed to support and assist CSRN Ms B in orienting herself to her role. It advised that it took steps to ensure CSRN Ms B possessed the required expertise and references for the role of CSRN. It provided her with a comprehensive orientation and numerous training opportunities, and advised her of the support and mentoring available to her from members of the senior team.

112. The rest home accepted that in a performance appraisal in Month 5, 2009, CSRN Ms B raised concern that she had not been fully oriented. It advised that in addition to the standard two-week orientation and training, the senior staff provided CSRN Ms B with supplementary training, counselling and assistance as issues arose.

113. The rest home also accepted that at CSRN Ms B's Month 5, 2009 performance appraisal, she raised concerns about a lack of co-operation and reporting from the RNs. The rest home advised that the Care Manager explained the processes available to CSRN Ms B to manage any performance issues with the staff she supervised, including the "poor work habits" process. The rest home stated that CSRN Ms B rarely used these processes to manage staff under her supervision, and did not alert the rest home to "the behaviours that resulted in the perceived deficiencies of care" in relation to Mrs A.

114. The rest home advised that it had internal controls to ensure issues with patient care were identified, reported and managed, including supervision and monitoring of employees by senior staff, monthly risk management meetings, and monthly weight monitoring of patients.

115. The rest home advised that CSRN Ms B's duties have been overstated. The rest home rejects CSRN Ms B's assertion that on most Thursdays and Fridays she was responsible for the clinical oversight of the whole facility. The rest home asserted that CSRN Ms B was at no time in sole charge of 180 residents, but that she was supported by the other CSRN and other senior staff on duty. The rest home also noted that CSRN Ms B did not raise concerns in relation to her workload during her employment there. It considered that if she believed residents' care was being compromised by overwork, it was incumbent upon her to raise this with the rest home.

116. The rest home also explained the rationale for the location of the CSRNs' office, which included having the CSRNs near to the Care Manager so that she could ensure

they spent 95% of their time on the floor, providing support, supervision and guidance.

117. The rest home explained further its expectations in relation to adequate handover between shifts, use of the services summaries and the ward diary, and reporting from the CSRNs to the Care Manager. It stated that the CSRNs were expected to read residents' notes/care plans and check the ward diary daily. It stated: "Prior to this investigation, it regarded this sort of professional discipline to be so fundamental as to 'go without saying'." The rest home stated that it also "expected that the CSRN would visit each resident and speak with him/her (and family members if present) at least once or more each day". This expectation was also not documented as the rest home advised that it was considered fundamental.

118. In summary, the rest home considers that its systems, supports and procedures were robust, reasonable, and responsible during the period under investigation, given the information it had at the time.

CSRN Ms B's response to first provisional opinion

119. CSRN Ms B no longer works at the rest home. She was given the opportunity to review the rest home's comments in relation to her responsibilities and the support available to her from other senior staff.

120. CSRN Ms B does not accept that the Education Co-ordinator acted as the second CSRN on Thursdays and Fridays, and considers that, given the Education Co-ordinator's experience and other responsibilities, it would have been very unfair to have expected her to do so. CSRN Ms B does not consider that senior staff were available to provide support to herself and CSRN Ms G to the extent maintained by the rest home. She noted that she never saw her preceptor[19] read each resident's notes/care plan each day or speak to each resident and/or their family at least once or more each day, and she does not believe that this had been usual practice.

121. CSRN Ms B provided further details in relation to her other responsibilities, including supporting nursing staff working in the hospice unit at the rest home,[20] preparing for the implementation of the Liverpool Care Pathway programme, wound care, ordering controlled drugs, bulk supply orders, and completing the "special authorities" for patients requiring liquid supplements.

122. CSRN Ms B acknowledged that in her staff appraisal she had raised the issue of staff not following instructions and reporting issues of concern. She noted that she was aware of the "poor work habits" process, but did not consider this appropriate in circumstances where "it was a case of continuous new staff not knowing what they did not know".

123. CSRN Ms G submitted information to HDC in support of CSRN Ms B. CSRN Ms G outlined her understanding and experience of the CSRN role and responsibilities, and the availability of clinical support from other senior staff. She stated that there were shifts when she or CSRN Ms B had sole responsibility for overseeing the care

[19] Teacher or instructor.
[20] The hospice contracts three beds within the area of the rest home in which Mrs A resided, for a dedicated palliative care unit.

provided to all 180 residents, and that at these times the level of responsibility was mostly "stressful and exhausting". She considers that in practice, she and CSRN Ms B had no clinical support from other senior nurses.[21]

124. Both CSRN Ms B and CSRN Ms G identified obstacles in relation to effective communication with the Care Manager.

125. HDC was unable to contact RN Ms O for further information. She no longer works at the rest home and is no longer resident in New Zealand.[22]

Responses to second provisional opinion

The rest home

126. In response to my second provisional report, the rest home submitted that it is at a substantial disadvantage in commenting further, given the time that has elapsed and the fact that most of the staff named in this report have left the organisation. Nevertheless, the rest home submitted that in its view, the issue of CSRN Ms B's workload is central to this complaint. It considers that in the absence of a finding that CSRN Ms B's workload was unreasonable, it is unfair for HDC to find the rest home in breach of the Code or to make any adverse comment about the rest home.

127. In my second provisional report, I requested and received further information from the rest home in relation to the induction and training information it provides to its staff. This included confirmation and evidence that:

- the induction and training information provided to all staff affirms the rest home's expectation that all members of the multidisciplinary team will ask questions and report concerns about, or changes in, a resident's condition; and
- the induction and training information provided to all staff reflects the rest home's expectations in relation to staff compliance with policies.

128. The rest home advised that it had taken steps to ensure there is a culture at the rest home that encourages the above actions. It stated that it keeps staff informed of all policies and procedures and updates staff when there are changes. It has policies that are designed to ensure information is disseminated, and staff are required to acknowledge receipt of this information. The rest home also has reporting tools to ensure information is shared, referred and acted on by the relevant staff member.

129. The rest home also advised that regular and comprehensive auditing of its practice is carried out and corrective actions are issued for any breach of policy. The rest home maintains a risk register to identify, manage and/or eliminate risk in any area, and the new Quality, Audit and Risk Manager is in the process of reviewing all key policies and researching best practice.

CSRN Ms B

130. CSRN Ms B submitted that it would have been impossible to read the notes for even 90 patients each shift if other work was to be done, let alone for the 180 patients for whom she was responsible on Thursdays and Fridays.

[21] CSRN Ms G also no longer works at the rest home.
[22] The information from RN Ms O contained in the "Background Facts" section of this report was taken from a statement she completed at the rest home's request, soon after it had received Dr A's complaint.

131. With respect to seeing all residents each day, CSRN Ms B stated that it was usual practice to walk around the wards to sight residents, but not all residents were necessarily available at the time. She states that an in-depth assessment of all residents would have been impossible in the time available.

132. CSRN Ms B submitted that after observing Mrs A's swallowing difficulty, she evaluated her intervention by following up verbally with an RN the next day.

133. CSRN Ms B also stated that her documentation in relation to Mrs A was as adequate as it could be, given the availability of time.

134. CSRN Ms B's response included a statement from another CSRN, who also stated that there were times when CSRN Ms B was rostered to be in sole overall charge of 180 residents. However, it is noted that this CSRN was not working at the rest home at the time of these events.

Opinion: Breach — The rest home

135. Mrs A had been a resident at the rest home for more than 10 years, and she had several chronic health conditions. Her daughter-in-law, Dr A, stated that in light of Mrs A's age and history, her death was not unexpected. However, the family's concern is with the quality of care provided to Mrs A leading up to her death. I share this concern.

136. There were repeated failures by multiple staff at the rest home to provide Mrs A with appropriate care. In the last weeks of Mrs A's life, nursing staff failed to adequately assess, monitor and respond to Mrs A's deteriorating condition. There were deficiencies in communication between nursing staff and medical staff, which were compounded by inadequate documentation. I consider that the rest home must take responsibility for the extent of such failures.

Assessment, monitoring, evaluation and management of Mrs A's condition

137. The nursing staff at the rest home failed to respond to Mrs A's changing health status during Month 6 and early in Month 7, 2009. Although Mrs A's deteriorating health was, at times, recognised, there is no evidence of new interventions being planned and implemented.

Care plan

138. No changes were made to Mrs A's care plan after Month 3, 2009. There is no evidence in Mrs A's care plan that her deteriorating health status had been recognised. The rest home's "Planning Care" policy requires care plans to be current, addressing the resident's current abilities, level of independence, and identified needs or deficits. The RNs and CSRNs were responsible for ensuring care plans met the required standards, but it is not clear who had ultimate responsibility for them. While there is evidence of six-monthly reviews, no changes were made to Mrs A's long-term care plan after the 30th of Month 3, 2009, and no short-term care plan was developed to address her changing needs in the weeks before she died.

Vital signs and observations

139. There is evidence of routine monthly blood pressure recordings and one-off observations in Mrs A's progress notes. The rest home stated that vital signs are checked on admission and then only on the instruction of senior staff or a doctor. I agree with Ms O'Connor that more regular monitoring of Mrs A's vital signs was warranted, in light of the apparent deterioration in Mrs A's condition, including two acute hospital admissions for rectal bleeding and a possible stroke within a four-month period.

Weight loss

140. Mrs A lost 2.2kg between Month 1 and Month 2, 2009, and her weight continued to trend downwards. By the end of Month 6, Mrs A had lost 4kg over the preceding five months. The rest home's "Weighing Residents" policy required an Accident/Incident Form to be completed for residents with weight loss of 2kg or more in one month, or 4kg or more within six months. This form would have triggered a referral to the dietitian or Medical Officer.

141. No staff member documented or responded to Mrs A's weight loss. Accident/Incident reports should have been completed in Month 2 and Month 6, but were not. Additionally, no mention of Mrs A's weight loss was made when her care plan was reviewed in Month 3. The only action taken to address the deterioration in Mrs A's appetite and food intake was on the 31st of Month 6, when CSRN Ms B happened to walk past, saw that Mrs A was having difficulty swallowing, and recorded in the progress notes that Mrs A should be having a puréed diet and thickened fluids.

142. The policy in force at the time stated that weighing residents was the responsibility of the RNs, HCAs and the dietitian, but was not clear as to who was responsible for completing the Accident/Incident form or escalating concerns about weight loss. However, CSRN Ms B advised that the RN in each unit was required to inform her of any weight loss and fill out the Accident/Incident form. The rest home advised that the Accident/Incident form is "seen and signed off" by the CSRN and forwarded to the Quality Co-ordinator, then the CSRN refers the resident to the dietitian. The CSRN job description required the CSRN to ensure Accident/Incident forms were "completed and actioned with accuracy". In Mrs A's case, this did not happen as it should have.

Fluid balance chart

143. Nursing staff failed to adequately monitor and assess Mrs A's fluid input and output after she was first noted to be dehydrated on the 27th of Month 6, 2009. A fluid balance chart was commenced on the 27th of Month 6 on CSRN Ms B's verbal instructions. CSRN Ms B did not record her instructions in Mrs A's progress notes or care plan. The fluid balance chart was completed erratically for four days, and not at all after the 31st of Month 6.

144. The rest home stated that it is the RNs' responsibility to ensure fluid balance charts are completed, and that CSRN Ms B should have ensured that her instructions were implemented. A number of the rest home staff failed in their responsibility to ensure that Mrs A's hydration levels were monitored adequately.

Pain management

145. I am concerned at how Mrs A's pain was managed. Between the 29th of Month 6 and the 2nd of Month 7, it is recorded that Mrs A was "unsettled", "in pain", "agitated and not comfortable" and "very unwell". Ms O'Connor advises that "[t]he daily frequency of Mrs A's agitation and restlessness could very well have been pain related and while this was recognised by some registered staff it was not consistent". No reassessment of Mrs A's medication or care plan was initiated.

146. The rest home's policy on pain management required residents' pain to be identified, assessed and managed. Ongoing monitoring of pain management is to be undertaken and documented, with any requirements for management change responded to promptly. While the responsibility for assessing and managing pain lies with the RNs and Medical Officer, the policy did not specify the frequency of assessments or reviews, or the systems for escalating concerns to senior staff.

147. As Ms O'Connor notes, there is no evidence of Mrs A receiving more than one dose of paracetamol in a day, no evaluation of its effect, and no ongoing evaluation of her pain levels. After finding Mrs A in "severe distress" on the 1st and 2nd of Month 7, Mr and Dr A personally arranged for a GP from another organisation to assess Mrs A and provide for alternative pain relief.

148. Mrs A's pain management was unacceptable. Dr A stated in her complaint that it was only after "appropriate medication for management and relief of suffering and distress" had been charted that Mrs A "was able to die with some dignity". Staff at the rest home should have been more proactive in ensuring Mrs A's pain was identified and responded to appropriately.

Summary

149. As Ms O'Connor notes, all of the RNs accountable for Mrs A's care had a responsibility to assess Mrs A, plan and implement interventions and evaluate their effectiveness in line with the New Zealand Nursing Council's scope of practice for registered nurses. The RNs also had a responsibility to report to the CSRN for clinical support. Ms O'Connor states that while "some staff may have recognised Mrs A's deteriorating health status and reported on various communication documents, no-one has documented a comprehensive nursing assessment and subsequent use of the nursing process in care provision".

150. I agree with Ms O'Connor that "the use of the nursing process: assessment, planning, implementation and evaluation, and subsequent care planning by the registered staff caring for Mrs A [was] insufficient".

Communication

151. The rest home failed to ensure adequate communication systems within the organisation. As noted in a previous Opinion:[23]

> "Good aged residential care is dependent on services being provided with reasonable care and skill. It requires the co-operation of everyone involved, and effective communication — between health professionals and with residents and families."

[23] Opinion 08HDC17309 (26 May 2010) p 20.

Communication between the rest home staff

152. There are discrepancies between the recollections of staff members in relation to the extent to which nursing staff reported their concerns to senior staff. The ineffectiveness of the system in practice was patently demonstrated on the 30th of Month 6, when RN Ms N attempted to pass on her concern that Mrs A may have had an oral abscess. After unsuccessful efforts to speak to CSRN Ms B, she documented her concern in two places, neither of which were read.

153. It is clear from Mrs A's records that the RNs documented their concerns about Mrs A's health on numerous occasions between mid-Month 6 and the 3rd of Month 7. However, CSRN Ms B stated that she was not aware of Mrs A's suspected oral abscess, swallowing difficulty (until she noticed it herself), weight loss, or Mr A's requests for Mrs A to be seen by a doctor. CSRN Ms B advised that it was not her practice to read the notes or ward diary each day, and that she relied on the RNs raising their concerns with her verbally.

154. RN Ms J and RN Ms L recall specific occasions when they did verbally raise concerns about Mrs A's health to a senior nurse, but say this was sometimes RN Ms O or CSRN Ms G. RN Ms O recalls staff verbally raising concerns about Mrs A's deteriorating condition. RN Ms O states that she reminded staff to report all changes to CSRN Ms B, and was reassured by staff that they had done so. CSRN Ms G stated that she had no involvement in Mrs A's care and, "I do not recall any staff member reporting to me any events or issues in regards to [Mrs A]."

155. The "Pain Management" policy was unclear about to whom concerns about residents should be reported, and who was ultimately responsible for management of residents' pain. The processes in place for alerting staff to concerns about a resident need to be effective, and known to all relevant staff. This is particularly necessary where there is a high staff turnover, employment of inexperienced staff, and the use of bureau staff who are likely to be less familiar with the policies and structure of an organisation. It is concerning that the means by which the RNs communicated their concerns about Mrs A, and CSRN Ms B's and the rest home's expectations for how the RNs would communicate their concerns, were not clearly aligned.

156. The systems at the rest home for communicating and escalating concerns about residents were inadequate. The rest home had several senior staff: two CSRNs, a Clinical Co-ordinator, an Education Co-ordinator, a Quality Co-ordinator, a Human Resources Executive, and a Care Manager; all of whom had responsibilities at times in relation to the clinical care provided at the rest home. In an organisation such as the rest home, where there are several senior staff with various responsibilities, the systems in place need to clearly indicate to the nursing staff which of the senior staff is responsible for what, and how concerns about residents should be escalated.

Communication between nursing staff and doctors

157. There was poor communication between the rest home staff and its contracted medical staff. This was particularly evident on the day Mrs A died, when CSRN Ms B and Dr C each thought the other had spoken with Mrs A's family, but neither had.

158. Mrs A's progress notes demonstrate that the HCAs and RNs were concerned about Mrs A's deterioration. However, there was a lack of action after the 28th of Month 6 2009, when her management should have been reviewed and concerns about her

health should have been communicated to the medical staff. As Ms O'Connor states, medical staff rely on nursing staff to request medical assessment on an acute basis. Dr D confirmed that the medical care for residents is dependent on nursing staff requests. He says that in his experience, the rest home nurses are very good at alerting doctors when acute care or advice is needed, but that this did not occur as it should have in the last few days of Mrs A's life.

159. The rest home advised that in its general experience of interactions between nursing staff and doctors, most nurses are likely to be reluctant to "prompt" medical staff to implement particular plans or take action. In my opinion, the rest home needed to encourage a culture where it is acceptable and even commonplace for questions to be asked, to and from any person in the multidisciplinary team, at any time.

160. The rest home staff's failure to communicate with the medical staff was compounded by confusion on the part of at least one nurse in relation to the availability of medical staff after hours. At the time of Mrs A's deterioration, medical staff were unavailable for visits after hours, but could be contacted by telephone for advice outside their usual hours at the rest home, and this included weekends and evenings up until 10pm. The doctors' roster, posted on a board in each area of the rest home, reflected this situation. However, a memo circulated to staff in Month 4 advised that "as from today (15/[Month 4]/2009) Housecalls are no longer in operation & there is no after hours, or weekend medical service". In my view, this message was confusing. The rest home had a responsibility to ensure that its staff were fully aware of the availability of medical staff, to ensure that residents received timely medical intervention.

Documentation

161. Between the 1st of Month 6 and the 3rd of Month 7, 2009, there were four days for which nothing was documented in Mrs A's clinical records. At the time of these events, the rest home's policy in relation to documentation was that there should be one entry in the progress notes by nursing/care staff every 24 hours and by exception, and that an RN should record in the notes twice a week and by exception. Ms O'Connor notes her particular concern that in the last weeks of Mrs A's life, there was a lack of entries by RNs. This made it difficult for staff to have an ongoing "picture" of Mrs A's condition.

162. The poor documentation was also evident in Mrs A's care plan. Changes to Mrs A's care that are recorded in the progress notes (the commencement of a fluid balance chart after Mrs A vomited on the 27th of Month 6, and a change in dietary requirements) were not reflected in Mrs A's care plan.

163. Documentation is important when there are several different people providing care. In the last few weeks of Mrs A's life, there were approximately ten RNs and nearly the same number of HCAs involved in Mrs A's care. In such circumstances, it is essential that details about observations, care, assessments, and instructions to caregivers are recorded regularly and accurately, so that any changes in the resident's condition can be noticed and responded to in a timely and appropriate manner. In Mrs A's case, this did not occur.

164. I agree with Ms O'Connor that the consistent and detailed use of care plans and progress notes is a valuable communication tool for all nursing and care staff. The rest

home staff's failure to appropriately use these tools compromised the continuity of the care Mrs A received.

The rest home's responsibility

165. I have carefully considered the extent to which the deficiencies in Mrs A's care occurred as a result of individual staff action or inaction, as opposed to systemic and organisational issues.

166. The rest home has acknowledged that there were shortcomings in the care provided to Mrs A. It considers that there were individual failings that cumulatively resulted in the service provided to Mrs A falling below expected standards.

167. The problems that arose with Mrs A's care were not the result of isolated incidents involving one or two staff. There were approximately ten RNs and nearly the same number of HCAs involved in Mrs A's care in the last few weeks of her life. I am concerned that many of the shortcomings were common to a number of staff. This pattern suggests that the systems and processes to support staff to fulfil their responsibilities were inadequate.[24] In any event, an employer such as the rest home is ultimately responsible for such widespread failures of its staff.

168. I acknowledge that, aside from the inadequate systems for communication, the rest home's policies and procedures appear to be satisfactory. However, without staff compliance, policies become meaningless. Ultimately, the rest home had a responsibility to ensure that all staff complied with the policies and provided services of an appropriate standard.[25] As stated in a previous Opinion:[26]

> "[t]he inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that does not sufficiently support and assist staff to do what is required of them. [The rest home] as an organisation must bear overall responsibility for this."

169. The rest home notes issues with staff turnover and with staff who were either new graduates or new to New Zealand standards. Around half of the RNs involved in Mrs A's care during her last weeks were agency nurses. The difficulties with staffing in the aged care sector are acknowledged, and these have been recognised in previous HDC investigations.[27] I acknowledge that bureau nurses were given a two-page memo about how to contact senior staff. However, the fact remains that the rest home had a duty of care to Mrs A to ensure a safe environment for her, and this duty was not properly discharged.

170. When the condition of a patient suddenly changes or is deteriorating, there is a need for more frequent assessments, clinical observations, medical reviews and communication with family members. Such situations are foreseeable in a facility that provides hospital-level care, and the management of such patients requires significant co-ordination. Given there was a high staff turnover and inexperienced staff, and agency nurses were being used on a frequent and ongoing basis, I would have

[24] This issue has previously been commented on in Opinion 07HDC16959 (20 May 2008) p 18.
[25] Opinion 08HDC17309 (26 May 2010) p 23.
[26] Opinion 09HDC01783 (28 March 2011) p 24.
[27] Eg, Opinion 08HDC17105 (26 August 2009).

expected the rest home management to be particularly aware of the need for robust and clearly understood systems, which ensured concerns about a resident's well-being are identified, reported and acted upon appropriately.

171. For the reasons outlined above, I do not consider that the rest home provided Mrs A with a reasonable standard of care. Moreover, I consider that the continuity and quality of Mrs A's care were compromised by a lack of co-operation, co-ordination and communication between those caring for her. Accordingly, I find that the rest home breached Rights 4(1) and 4(5) of the Code.

172. The rest home is to be commended on the steps taken to address the issues this complaint has raised, including staff reporting and communication when there are concerns about a resident's health and well-being.

Adverse comment

173. There are further aspects of the care provided by the rest home and its staff that I consider could have been improved, but do not consider amount to a breach of the Code in the particular circumstances of this case.

Interaction with Mrs A's family

174. Mr A asked nursing staff if he could speak to a doctor on the 21st of Month 6, 2009, and made several further attempts over the following fortnight. There is no evidence that either Dr D or Dr C were asked by nursing staff to contact Mr A. The rest home states that it is difficult to establish exactly what happened with regard to the facilitation of a meeting between Mr A and Dr D or Dr C. It appears that on some occasions, this message was passed between nursing staff, and that on other occasions the CSRN thought she had been able to address Mr A's concerns.

175. Mr A was not legally entitled to make decisions about his mother's care as the EPOA was never invoked. However, the views of family members are important.[28] If greater regard had been paid to Mr A's request for medical review, more appropriate pain relief may have been administered sooner to alleviate Mrs A's distress. Mr A knew his mother well, and it is clear from the records that his involvement in her care was in accordance with her wishes. When Mr A recognised that Mrs A was not well and asked for medical review, the rest home staff should have taken steps to appropriately address those concerns, either by contacting a doctor to discuss whether a review was required, or by arranging a review directly. It is evident that the staff's failure to do so in these circumstances was compounded by the poor systems at the rest home for communication with families and for the escalation of concerns.

Advance directives

176. Mrs A had signed an advance directive indicating, among other things, a preference for comfort cares. Advance directives come into effect in the event that a consumer becomes incompetent.[29] The rest home advised that different protocols apply for patients who require active treatment and investigation, and those who require comfort cares. While having different protocols is appropriate, the rest home needs to be sure that the basis on which a protocol is chosen is correct. It would be incorrect to rely on Mrs A's advance directive to provide comfort cares only, when her advance

[28] Opinion C08HDC17105 (26 August 2009).
[29] Clause 4 of the Code.

directive had not come into effect. If a resident is competent to consent to either active treatment or comfort cares, consent should be obtained.

177. I am concerned about the "advance directive" completed on the 21st of Month 4, 2009 by RN Ms E and Dr D, but not by Mrs A. Under the Code, only a consumer of health and disability services can make an advance directive.[30] However, the form used by the rest home states that the advance directive can be completed by a medical practitioner. If certain treatment is not clinically appropriate, a clinician can make a care plan in which it is stated that the treatment should not be given. However, that would be a clinical decision, not an advance directive, and should not be mistaken as such. The rest home should have a system in place for advance directives and clinical decision-making that does not confuse these points.

178. I agree with the comment from a member of Mrs A's family that systems are important for the pain care and dignity of everyone, irrespective of their resuscitation status.

Communication of expectations

179. Over the course of this investigation, disagreement has emerged between the rest home and the two CSRNs in relation to the nature and extent of their responsibilities. CSRN Ms B maintains that on Thursdays and until 3pm on Fridays, she was the only CSRN on duty and was therefore responsible for overseeing the nursing care across the entire 180-bed facility. However, the rest home states that CSRN Ms B never had sole responsibility for 180 residents. It states that the Education Co-ordinator worked as the second CSRN on Thursdays and Fridays, and that there were a number of other senior nurses available to provide clinical support. CSRN Ms B advised that, in practice, this never occurred. CSRN Ms B's view is supported by CSRN Ms G, who advised that on certain days she too had sole responsibility for nursing care across the entire facility.

180. The reasons for the lack of a common understanding here remain unclear. The CSRNs had a period of orientation, a position description and performance appraisals. These factors may indicate that the rest home took steps to communicate its expectations to the CSRNs. However, it is clearly unsatisfactory that CSRN Ms B and CSRN Ms G had a different understanding of the number of residents for whom they were responsible than that of the rest home.

181. Ms O'Connor commented that "believing some tasks are so fundamental that they 'go without saying' is perhaps not a healthy attitude when you have obligations to meet in care provision". I agree with Ms O'Connor that the lack of a common understanding between the CSRNs and the rest home highlights the importance of employers effectively communicating their expectations to their employees. Residential facilities have a range of staffing structures, with associated variations in staff roles and responsibilities. Quality care relies on each person in the team having a clear understanding of their respective roles and responsibilities.

Availability of after-hours medical care

182. According to the "Age Related Residential Care Services Agreement" with the DHB, the rest home was contractually obliged to ensure that "[o]n-call emergency medical

[30] See Clause 4 of the Code.

services are available to all Subsidised Residents at all times". As noted above, it appeared that the rest home was unable to meet this obligation.

183. However, I note that the rest home had informed the DHB that it was not able to meet this requirement, and outlined the steps it was taking to address the problem and the actions to be taken if a resident required after-hours medical attention in the meantime. Residents and/or their families were also informed. While the situation at the rest home in this regard was far from ideal, there is evidence that the rest home had recognised this and was taking active steps to address the matter.

Opinion: Adverse comment — Ms B

184. Ms B was one of two CSRNs overseeing the care provided at the rest home. She had primary responsibility for approximately 90 residents in two hospital wards (including the area in which Mrs A resided) and one rest home ward.[31] She had additional facility-wide responsibilities.

185. The rest home advised that the RNs are responsible for planning and reviewing the care of hospital residents, and documenting this appropriately, and the CSRNs are responsible for ensuring that this is done. CSRN Ms B stated that at the beginning of each month the CSRNs check that the care plans, care reviews, weight charts and medication charts are up to date.

186. The notes show that during the last month of Mrs A's life, CSRN Ms B saw her on the 27th and 31st of Month 6, and the 3rd of Month 7, and that she was consulted by nursing staff in relation to Mrs A on the 21st and 28th of Month 6. CSRN Ms B requested that Mrs A be medically reviewed on the 21st of Month 6, the 27th of Month 6, the 28th of Month 6, and the 3rd of Month 7.

187. CSRN Ms B stated that she was unaware of certain changes in Mrs A's condition, including a suspected oral abscess, swallowing difficulty (until she noticed it herself) and weight loss. Mrs A's deteriorating health is documented in her clinical records on numerous occasions from the 29th of Month 6, including notes that Mrs A was in pain and was having difficulty swallowing. Mrs A's pattern of weight loss was also evident from her records. However, CSRN Ms B stated that it was CSRN practice at that time to rely on verbal handovers from the RNs, rather than reading patient notes.

188. In her performance appraisal in Month 5, 2009, CSRN Ms B flagged concerns about staff not reporting issues to the CSRNs or night RN supervisor, and asked for management support in dealing with staff resistance. CSRN Ms B was advised to report those matters to human resources or the Care Manager, and was reminded of the process for dealing with staff who were failing to perform. CSRN Ms B later explained that she did not consider this process was appropriate in the circumstances.

189. CSRN Ms B was responsible for monitoring the care provided to Mrs A by multiple health care providers, many of whom were not regular rest home employees. It was

[31] As noted above, there is dispute over the number of residents CSRN Ms B was responsible for on Thursdays, and Fridays until 3pm.

thus important for her to know about changes to Mrs A's condition. Ms O'Connor notes that clinical staff have a responsibility to at least receive a verbal handover, check the ward diary and any communication sheets, read the notes and/or care plans for any resident whose status has changed, and then view those residents and assess them each shift. In my opinion, given that Mrs A's condition had changed, CSRN Ms B should have been reviewing Mrs A's notes.

190. There are other aspects of the care provided by CSRN Ms B that fell below expected standards. As Ms O'Connor notes, CSRN Ms B should have updated Mrs A's care plan to reflect the interventions she (CSRN Ms B) requested, particularly the change to Mrs A's diet and the commencement of a fluid balance chart. In addition, CSRN Ms B should have evaluated her requested interventions. CSRN Ms B advised HDC that she followed up verbally with an RN about Mrs A's progress with the thickened fluids, and the RN advised that Mrs A was "tolerating them well". However, there is no record of this, and the entries by an RN late on the 31st of Month 6 and an HCA on the 1st of Month 7 indicate that Mrs A was not tolerating the thickened fluids. It is also evident that CSRN Ms B poorly documented her involvement in Mrs A's care. Ms O'Connor considers that CSRN Ms B's documentation does not reflect that of an "advanced practitioner", and states that the level of documentation by CSRN Ms B would be viewed by her colleagues with "mild disapproval".

191. I agree with Ms O'Connor that aspects of the services provided by CSRN Ms B to Mrs A could have been better. However, conflicting information has been provided in relation to CSRN Ms B's workload and the level of support she received from the rest home. In light of this, I am unable to reach a conclusion about the extent to which the workload and available support impacted on her ability to provide services of an appropriate standard.

192. CSRN Ms B maintains that she was the only CSRN on duty on Thursdays and until 3pm on Fridays, and was responsible for overseeing the nursing care throughout the entire 180-bed facility at those times. However, the rest home stated that CSRN Ms B never had sole responsibility for 180 residents, and that the Education Co-ordinator worked as the second CSRN on Thursdays and Fridays. CSRN Ms B disagrees, and states that in practice this never occurred.

193. Commenting on the basis that CSRN Ms B was responsible for 180 residents at times, Ms O'Connor initially considered that her workload was "overwhelming and unacceptable". However, after reviewing the rest home's account, Ms O'Connor stated that if CSRN Ms B was responsible for overseeing the care provided to 90 residents rather than 180 residents on Thursdays and Fridays, the workload would have been "far more achievable". However, she also states that it is "perhaps important to note that the rest home has now restructured and disestablished the Clinical Co-ordinator position and employed a third full-time CSRN".

194. It is unclear whether the systems in place to support the CSRNs in their role were operating effectively. The rest home stated that there were a number of other senior nurses available to provide clinical support to the CSRNs, while CSRN Ms B states that, in practice, this was not the case.

195. CSRN Ms B's view on the CSRNs' workload and the level of support the CSRNs received is supported by CSRN Ms G. This Office has been unable to contact RN Ms

O (who is currently living overseas), who may have been able to clarify whether, on a day-to-day basis and taking account of her other duties, she was fulfilling the second CSRN role on Thursdays and Fridays. In my view, I have insufficient evidence to make a finding as to whether CSRN Ms B's workload was achievable, or whether the support available to the CSRNs was adequate.

196. CSRN Ms B was an experienced nurse but she had been in her position at the rest home for a relatively short time. Closer oversight of the RNs by CSRN Ms B may have improved the standard of nursing care provided to Mrs A. However, I have insufficient evidence to determine the extent to which the concerns identified in relation to the care CSRN Ms B provided were the product of an excessive workload or inadequate support in her workplace. Nevertheless, I consider that CSRN Ms B should reflect on her contribution to the poor care provided to Mrs A.

Recommendations

197. I acknowledge the steps taken by the rest home to address the concerns Mrs A's family had about the care she received, both in response to Dr A's initial complaint and in response to the recommendations I made in my second provisional opinion. The rest home has apologised to Mrs A's family for the aspects of the care they identified as being deficient. I am satisfied that the rest home has taken action since and/or as a result of this complaint to address the issues raised and to improve the service it provides.

Follow-up actions

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the New Zealand Nursing Council, and it will be advised of CSRN Ms B's name.

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the relevant District Health Board and HealthCERT (Ministry of Health), and they will be advised of the rest home's name.

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1 — Expert nursing advice

"Complaint: [Mrs A] (dec)
Reference: 09/01641 Date: 22 August 2010

I have been asked to provide a nursing opinion regarding the standard of care that [Mrs A] received by [the rest home] for the period [Month 3 to Month 7, 2009]. I have read the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Professional profile
Since registering as a Comprehensive Nurse in 1989 I have completed a Bachelor of Nursing (2001), Graduate Certificate in Hospice Palliative Care (2002) and a Masters of Nursing with a clinical pathway (2008). My initial nursing experience was as a Public Health Nurse after which I moved to the hospital setting first in orthopedic nursing then acute/general medical in a rural hospital. Following this I embarked on an overseas trip where I worked firstly as an agency nurse in various hospital wards then in the community setting as a district nurse in London. Also in London, I worked for 9 months in a Nursing Home for older people before returning to New Zealand and commencing nearly 5 years in Assessment, Treatment and Rehabilitation. In this setting, I coordinated a 12 bed unit and completed needs assessments for older people in a large geographical area. For the past nearly 12 years I have been working for a non-profit charitable organization managing various aged care facilities. My current facility is a retirement village of 60 beds, residential, hospital and dementia levels, and 21 cottages. I am current chair of the facility's Quality team and the organization's Clinical Practice Group. I have managed my facility through many changes in care provision and enjoyed successful audits. I am a member of the New Zealand College of Nurses and enjoy providing education and insight into care of the older person for various groups in my region.

Expert Advice required
[Omitted for brevity]

Supporting Information
[Omitted for brevity]

Background
[Mrs A] (93) was a long term hospital resident at [the rest home]. Her condition and function had been deteriorating for several weeks since being diagnosed and treated for a urinary tract infection on [the 21st of Month 6]. She was reviewed by [Dr D] on [the 23rd of Month 6], with no change in treatment prescribed. However her condition continued to deteriorate with poor appetite and an increase in confusion and/or restlessness. A further medical review on [the 27th of Month 6] with [Dr C], requested by nursing staff, suggested she may have suffered a trans ischemic attack (TIA) or cerebrovascular accident (CVA). [Dr D] was again asked to review her the following day due to Clinical Support Registered Nurse (CSRN) [Ms B's] reluctance to commence Aspirin. Blood tests were ordered and lithium (due to elevated levels) and aspirin were withheld.

Over the next 4 days [Mrs A's] condition continued to deteriorate. She was noted to have difficulties swallowing and was restless and distressed at times. The family became concerned and arranged for an urgent doctor service to visit the evening of [the 2nd of Month 7]. This General Practitioner (GP) also considered she may have had a slight stroke and noted she was agitated and dehydrated. He prescribed morphine and an antipsychotic and requested further GP review the next day. [On the 3rd of Month 7] [Dr C] reviewed her and noted her condition was terminal, discontinued all medications except for morphine. [Mrs A] died that evening.

[THE REST HOME]

1. Standard of nursing care

a) Nursing assessment, monitoring and reviewing of [Mrs A's] condition

The nursing staff failed to implement basic nursing requirements in the form of observations when this lady became unwell. There is evidence of routine monthly blood pressure recordings and several individual nurses recorded observations on one off occasions in progress notes in response to [Mrs A] being unwell but these are not displayed on a chart. Given the timeframe of the progress notes provided, [Mrs A] had two acute hospital admissions related to PR bleeding and suffered a possible stroke, then one would expect the registered staff to be monitoring vital signs as a form of assessment of health status. [The rest home states] that these are done on admission, at doctor's reviews and then only commenced at Doctors or senior staff instructions. However it is in every registered nurse's scope of practice to provide comprehensive nursing assessments (New Zealand Nursing Council, p.3, 2007).

According to [Mrs A's] weight chart her weight in [Month 1] was 65.5kg and dropped to 63.3kg in [Month 2], this equates to a 2.2kg weight loss. There is also a continual downward trend evident in her weight chart through to [Month 6]. Difficulties with swallowing and poor appetite on occasion are reported in the progress notes as early as [the 16th of Month 6, 2009]. Also a Medacs RN recorded, in her subsequent statement, her visual observation of a weight loss. No recognition or interventions are recorded in [Mrs A's] care plan on the management of any weight loss except by [CSRN Ms B] who records a change in diet requirement to purée and thickened fluids on [the 31st of Month 6] and this was in response to her observing poor swallowing. There is no earlier evidence that [Mrs A's] weight loss was recognised or her needs reassessed and interventions planned to stabilise or improve her weight. In the Resident Care Plan pertaining to 'Meals and drinks' the review that occurred on [the 30th of Month 3] makes no mention of weight trends as other entries have. Policy states that the RN/EN/HCAs all have the ability to discuss referral to the dietitian with the CSRN whose ultimate responsibility it becomes to arrange however no staff member took the opportunity to assess her weight recordings and plan care by referral or otherwise. The rest home's policy 'Weighing residents' is certainly a robust process once weight loss has been identified and associated care plans adequate. According to the policy and procedure all residents are to be weighed on admission, at 1 or 3 monthly clinical review in residential units or otherwise as directed by the Medical Officer. Staff are responsible for recording the weights and to refer any discrepancies to Medical Officer/Dietitian.

[CSRN Ms B] first recorded that this lady was dehydrated on [the 27th of Month 6]. Medical staff noted her to be a 'bit dry' on [the 28th of Month 6]. [CSRN Ms B] made instruction to push fluids orally on [the 27th of Month 6] and in an unsigned entry on the same day an RN comments that 'fluid chart in progress'. The CSRN says in her letter of response that she verbally asked staff to commence a fluid balance chart but this is not recorded in her progress notes entry. Fluid balance charts dated 27, 28, 29, 31 [Month 6] are evidenced however they have not been completed by those staff accountable for [Mrs A's] care on those days which would make assessment difficult should it have occurred. The rest home's Care Manager states that it is the RN's responsibility to ensure they are completed and the CSRN should also have checked that her instructions were being carried out, what the outcomes were and reported the findings to the GP if necessary. No evidence that this was done has been found.

On [the 30th of Month 6] an RN reported that she had followed up a report from a caregiver and found [Mrs A] to have a possible oral abscess. This is supported by her recollections of her shift on this date. The RN left a written message for [CSRN Ms B] to follow this up in the communication diary and documented in the progress notes but [CSRN Ms B] was not contacted by the RNs about the abscess nor did she read the entries in the diary or progress notes. There is no record of further assessment or treatment. [Dr R] did note in his review of [Mrs A] on [the 2nd of Month 7] that there was no evidence of a painful lesion but did not specify where he examined.

Paracetamol 1 gram 4 hourly was prescribed on [the 19th of Month 3] for [Mrs A]. Single doses were given on 20, 21, 29, 30 and 31 [Month 6] and also 1 & 2 [Month 7]. According to the progress notes on [the 29th of Month 6] [Mrs A] was assessed by an RN to be in pain and was given a single dose of paracetamol as prescribed. On [the 31st of Month 6] she was assessed by an RN as being very distressed and restless, no intervention was given. On [the 1st of Month 7] she was assessed by the afternoon RN as agitated and query in pain and given a single dose of paracetamol as prescribed. The same RN reviewed [Mrs A] at 1230 hours the following day and found her to be 'agitated and not comfortable' and requested a Doctors review the next day for 'lV/SC meds'. The same RN administered a single dose of paracetamol as prescribed at 1400 hours. The afternoon RN reported [Mrs A] as 'unsettled ++ and calling out' but did not complete any assessment for pain nor administer any pain relief until the family arranged GP prescribed it later that evening. [Mrs A] was obviously found to be in pain and distressed by her son that afternoon and they took their own action in organising a GP assessment for later that evening feeling it could not wait till the next day. The daily frequency of [Mrs A's] agitation and restlessness could very well have been pain related and while this was recognised by some registered staff it was not consistent. There is no evidence of [Mrs A] receiving more than one dose of paracetamol in a day, no evaluation of its effect and no ongoing evaluation of her pain levels. This has led to no proactive planning for more effective analgesia as it was to be required on the afternoon/evening of [the 2nd of Month 7]. It has been noted in additional information supplied by the rest home's Care Manager that retrospectively both [Dr D] and [CSRN Ms B] stated that they formed the view that [Mrs A's] agitation was related mainly to her Lithium toxicity and they did not consider her terminal until the day she died having possibly suffered another acute event overnight.

[The rest home] and their appointed lead facilitator, [Ms B], are to be congratulated on the successful implementation of the Liverpool Care Pathway for care of dying

residents since this complaint was lodged, as evidenced in their reports. [The rest home] has also reviewed their pain management policy and new documentation which they have implemented with extensive training. 'Clinical Assessment Skills' education sessions commenced in April 2010 and 'Problem Solving and Critical Thinking' introduced in June 2010.

I also note that [the rest home] have changed their clinical support structure since this complaint by disestablishing the Clinical Coordinator position and employing another CSRN thus decreasing the responsibilities of the existing CSRNs. This should in effect make the CSRNs more available in their areas of responsibility.

b) Adequacy of response to [Mrs A's] changing health status in [Month 6] 2009

It is my view, given the documentation I have reviewed, that nursing staff have failed, on occasion, to respond to [Mrs A's] changing health status during [Month 6 and early Month 7] 2009. This is evidenced by the lack of assessment (observations, pain, fluid input and output, weight), planning and implementing interventions and evaluating their effectiveness. All registered nurses accountable for [Mrs A's] care during this period have a responsibility to complete this and report to the CSRN for clinical support. NZNC says in defining the registered nurse scope of practice that they 'provide comprehensive nursing assessments to develop, implement, and evaluate an integrated plan of health care, and provide nursing interventions that require substantial scientific and professional knowledge and skills'. While some staff may have recognised her deteriorating health status and reported on various communication documents no-one has documented a comprehensive nursing assessment and subsequent use of the nursing process in care provision.

This assessment process should accumulate in referral for medical review if warranted. [The rest home states] that there may be several reasons why the process of assessment and referral to medical staff for review is difficult for nurses within this environment. Firstly, they have reflected on [Dr A's] comments that she feels the Nurses appear to be intimidated by the Doctors and have taken steps to try and remedy this through meetings and increased communication on Doctors rounds. [The rest home] also acknowledge their 35% turnover of staff in [the year from Month 5] and many new recruits are either new graduates and/or new to New Zealand standards. [The rest home does] employ both a full time Human Resources Executive and a part time Education Coordinator who provides both one on one training and planned group sessions and orientation.

c) Standard of documentation by nursing and care staff

Progress Notes

There are days in the progress notes that no entries have been made ([8, 19, 25 of Month 6]). The facility policy states that progress notes must be written in every morning shift by the RN or HCAs and 'by exception' by registered staff on other shifts. [The rest home] Care Manager has identified that there were other times that entries should have been made by RNs. NZNC says an indicator for accurate documentation is that the RN maintains clear, concise, timely, accurate and current client records (p.16, 2007). The lack of documentation does not demonstrate the nursing care that may have been provided on the day or [Mrs A's] status on that day. I am concerned about the lack of entries especially by the RN's in the last weeks of

[Mrs A's] life where an ongoing 'picture' of her condition is necessary for all staff in order to provide appropriate care.

[The rest home has] since reviewed their Health records policy twice to promote greater accountability and responded to Doctors' requests that they have a separate section for their own progress notes.

2. Care planning

[Mrs A's] care plan has been reviewed six monthly as per contractual obligations and the facility policy but there is no evidence of new interventions being planned and implemented as this lady's health status deteriorated. Last date for review of the care plan or any additions was [the 30th of Month 3]. Therefore, the use of the nursing process utilizing assessment, planning, intervention and evaluation by registered nurses is not evident within this documentation except, in part, by the two assessments made by the CSRN [Ms B] and recorded in the progress notes. The first being an assessment made after [Mrs A] vomited and the second a change in diet requirement to purée and thickened fluids. These changes to care are not reflected in [Mrs A's] care plan and indeed her 'Meals and drinks' states she still enjoys 'normal thin fluids'. Unfortunately no follow-up evaluation of any interventions was evident except that she choked on thickened fluids.

The current Age Related Residential Care (ARRC) services agreement requires providers to contractually comply with the following in relation to care planning:

016.3 [Care planning]

d) Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status;
g) The Care Plan addresses the Subsidised Resident's current abilities, level of independence, identified needs/deficits and takes into account as far as practicable their personal preferences and individual habits, routines, and idiosyncrasies;
h) The Care Plan addresses personal care needs, health care needs; rehabilitation/habilitation needs, maintenance or function needs and care of the dying;
i) Each care plan focuses on each Subsidised Resident and states actual or potential problems/deficits and sets goals for rectifying these and detail required interventions;
k) Short term needs together with planned interventions are documented by either amending the Care Plan or as a short-term Care Plan attached to the Care Plan;
l) Care plans are available to all staff and that they use these Care Plans to guide the care delivery provided according to the relevant staff member's level of responsibility.

D16.4 Evaluation
a. You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, whichever is the earlier.

[The rest home's] 'Ongoing assessment and Planning Care' policy equates with this but compliance was not evidenced in either [Mrs A's] current care plan or in a short

term care plan that could have been developed to enable staff to meet [Mrs A's] increased needs following her possible stroke and subsequent care. 'Planning care' policy states that it is the responsibility of the Registered Nurse of each unit for assuring the standards of the care plans are maintained and the CSRN's responsibility to monitor the RN's performance and act as a resource for them. Ultimately it is each RNs responsibility on duty to use the nursing process in planning care and subsequent documentation but as a part of the quality processes there should be a delegated responsibility to ensure compliance. [The rest home has] since reviewed their format for care plans and hope to implement this with education and monitoring in the near future and introduced a care review form to promote accountability. I assume education will accompany this.

3. Adequacy of communication

a) Between nursing staff and care staff

There is concern around the communication between the CSRNs and the RNs responsible for [Mrs A's] care. This is evidenced by [CSRN Ms B] stating she did not receive notification to review [Mrs A] regarding her mouth ulcer as recorded in the communication diary. She states that it was not practice of the CSRNs to read the ward diaries as these were for communication between staff on the ward. She says that they visited each area every morning for a verbal report. Also, [RN Ms L] reports that she informed [CSRN Ms G] on the afternoon shift of [the 2nd of Month 7] that the family had arranged their own GP review for [Mrs A], however, [CSRN Ms G] denies this. It would appear that there was an issue with communication between RNs on the ward and supporting clinical nurses which affected [Mrs A's] care. [The rest home feels] this is due to individual failings as some staff have stated that they have reported to senior staff and senior staff deny this.

The Managers' reports for the period [28–30 Month 6] all mention [Mrs A's] deteriorating health status. The Duty Manager's report for [the 2nd Month 7] makes no mention of [Mrs A's] deteriorating health status and the family facilitated GP visit. However, [the rest home] does have 24/7 on call arrangements for nursing support available and changes have been made to the daily service summary including implementing a communication log. [CSRN Ms B] states that she now has to visualize each resident in their areas and read all notes and the ward diary before receiving a verbal report.

Care plans are a form of communication for all nursing and care staff providing hands on care for any resident. In [Mrs A's] case the care plan was not kept up to date therefore I suggest this lack of communication affected the provision of appropriate and consistent care by all staff providing care.

b) With medical staff

According to the ARRC agreement providers of long term aged care in New Zealand are reliant on medical staff (usually in primary health) to provide a service to their residents. This can be alongside their core business elsewhere where they make time for regular resident reviews and acute visits. Not having ready access to medical staff provides nursing staff with the challenge of having to assess residents for differential diagnoses and be able to refer for further assessment and intervention if necessary. This means that medical staff do rely on nursing staff to request medical assessment

on an acute basis. Having a large number of inexperienced staff will not aid this assessment process. However the increase in clinical support staff will perhaps allow them to be more accessible to the RNs.

[The rest home] has experienced difficulties with securing Doctor Services, especially out of hours, which is becoming an issue for providers throughout New Zealand. In response to this the ARRC agreement has now been changed to allow Nurse Practitioners to provide services in aged care facilities that were previously a Doctor's responsibility.

It appears there was also some confusion regarding the on call services available during this period. [The rest home has] changed the instructions posted in the nurses' station to alleviate this.

c) With the medical staff and family

It appears that there were some instances where the registered nurses 'did not report to senior staff nor did they follow up to ensure that a Doctor was requested to talk with [Mr A]'. [The rest home] has found from interviewing the Doctors that no staff directly requested them to talk with [Mr A]. [The rest home] has admitted that they cannot 'establish exactly what happened in relation to the facilitation of meetings' between family and Doctors. It appears there was confusion with regards to the availability of an after hours medical review and this was conveyed to family on the afternoon of [the 2nd of Month 7] and prior on [the 21st of Month 6] when [Mr A] requested to speak to a Doctor regarding his mother's illness and spoke to [CSRN Ms B] instead.

The ARRC agreement requires providers [to act in accordance with the following]:

D16.3 [Care Planning]
f. Each Subsidised resident and his or her family/Whanau have the opportunity to have input into the Subsidised Resident's care planning process;

D16.4 Evaluation
b. You must notify the Subsidised resident's family members, with the Subsidised Resident's consent, as soon as possible, if the Subsidised resident's condition changes significantly;

Once again this is reflected in [the rest home's] policy.

There is evidence of [Mr A] being informed of his mother's condition on [the 30th of Month 6] and again on [the 3rd of Month 7] when her condition was considered terminal. However, [Dr A] states that her husband 'attempted on a number of occasions over a two week period, to clarify issues and the likely prognosis for [Mrs A]'. It is unclear as to whether the decision to stop medications and provide comfort care was a decision made in consultation with the family or if they were merely informed of this. Surely this is a scenario that calls for the Doctor involved giving the family information and allowing them to make an informed decision even with the presence of the advance directives. Not involving the family in the decision making process violates all expectations in both the ARCC agreement and the Health and Disability Services Standards. Nursing staff had an opportunity to prompt/facilitate a

meeting between the Doctor and [Mrs A's] family to discuss her prognosis following her first possible CVA so that they could be informed of her diagnosis and prognosis, and participate in planning her future care, thus preparing them for the possible outcome of death.

d) With [Mrs A] and her family

There is evidence in the progress notes of discussion with [Mrs A's] family on [the 3rd, 11th, 23rd of Month 3] (at [Mrs A's] request), [the 27th and 29th of Month 4, the 20th and 30th of Month 6, and the 2nd of Month 7] by nursing staff. Most entries are in response to the family making contact. Of concern is that there is no entry recording that [Dr and Mr A] were informed that [Mrs A] had a urinary tract infection on [the 21st of Month 6] despite phoning with concerns on [the 20th of Month 6]. Also there is no entry on [the 27th of Month 6], after the Doctor's review, recording that staff had informed the [A family] that [Mrs A] had possibly suffered a stroke. There is an entry that states son was informed of [Mrs A's] condition on [the 30th of Month 6] and on [the 3rd of Month 7] by an RN. Competency 3.2 of a registered nurse states that the RN acknowledges family/whanau perspectives and supports their participation in services (NZNC, p.26, 2007). While this was accomplished on some occasions it appears the family were not fully informed at all times.

4. Changes made since complaint by [the rest home]

[The rest home] management are to be commended on their own investigation into this complaint and the steps they have taken to address the significant issues identified by both internal and external investigation. While I agree that their systemic processes appear to be sound and there may have been a number of individual failings in the provision of nursing care at [the rest home], compounded perhaps by high turnover of staff, subsequent employment of inexperienced staff and the use of bureau staff. Connected to the issue of care planning is the question of the [ability of] nursing staff employed at [the rest home] to complete the nursing process, particularly assessment. Was there more evidence of this occurring then quite possibly more proactive nursing care would have prevented a number of the nursing care issues identified in this report. [The rest home] also has a responsibility to ensure that these processes occur.

I would like to acknowledge the [A family's] reiteration that the 'observed nursing care was at all times professional and appropriate'. However, I find that the evidence of care provided in the documentation to fall short of required standards. It is my opinion that the use of the nursing process; assessment, planning, implementation and evaluation, and subsequent care planning by the registered staff caring for [Mrs A] to be insufficient. Coupled with the communication issues this has, in turn, affected the adequacy of the response to her deterioration. This would be viewed by nursing colleagues and monitoring bodies with moderate disapproval as it is within the competencies of every registered nurse.

[CSRN Ms B]

1. Standard of care provided between [Month 6 and Month 7] 2009

[CSRN Ms B] documents the following involvement in [Mrs A's] care:

[25th of Month 5, 2009] [CSRN Ms B] was involved in a Doctors review of [Mrs A] where lithium toxicity was discussed and her warfarin was stopped. No documentation by [CSRN Ms B] is found in the progress notes.
[21st of Month 6, 2009] She had discussion with an HCA re [Mrs A] following a fall and evident disorientation. [CSRN Ms B] says she requested a urine specimen for possible urinary tract infection. No evidence of her instructions or involvement is found in the progress notes nor of follow-up.
[23rd of Month 6, 2009] A doctor's review was completed, unsure if [CSRN Ms B] attended as not evidenced in progress notes.
[27th of Month 6, 2009] Informed by staff that [Mrs A] was unwell and vomiting so she examined her and gave medication and organized a Doctor's review. This is evidenced in the progress notes. States she verbally asked for a fluid balance chart to be commenced; not evidenced.
[28th of Month 6, 2009] Concern re commencement of aspirin as prescribed by Doctor previous day asked another Doctor to review which occurred. Unsure if [CSRN Ms B] did attend as there is no evidence in progress notes and she was unaware bloods were ordered. No evidence she followed up the outcome of the review either.
[31st of Month 6, 2009] When walking past [Mrs A's] room (no purposeful visit) found her to be distressed and coughing with fluid pouring from her mouth. Her entry gives her assessment and plans for a puréed diet and thickened fluids.
[3rd of Month 7, 2009] Was informed of [Mrs A's] deterioration and visited her to assess. She inserted an insuflon and informed [Mrs A's] sister which is documented in progress notes. She also arranged for her to see a doctor.

Although [CSRN Ms B] states she oversaw the hospital areas and dealt with any emergencies or problems the RNs were responsible for the overall care and subsequent care planning. I am unsure whether the CSRN attended with the Doctors on their reviews. I can find no evidence of times when [CSRN Ms B] did not respond to requests for clinical support with [Mrs A]. Her failing is in perhaps not evaluating her requested interventions e.g. Fluid Balance Charts.

I have already outlined the issues with communication between the RNs and [CSRN Ms B] regarding a request to review [Mrs A's] mouth. These issues in communication no doubt affected [CSRN Ms B's] ability to respond in this instance.

On reviewing [CSRN Ms B's] curriculum vitae I note she is a New Zealand degree trained nurse. She has had extensive experience in acute medical and palliative care areas and some experience as an agency nurse in aged care facilities. She commenced work at [the rest home] on [the 2nd of Month 1]. I would question whether [CSRN Ms B] has the advanced assessment skills required to be in a position such as this although on paper she appears to have the experience. Her level of documentation does not reflect that of an advanced practitioner, for example, there is no framework used for example SOAPE — subjective, objective, assessment, plan, evaluation. [CSRN Ms B] herself has identified her need for further education which is commendable.

2. Adequacy of induction/orientation at [the rest home]

[CSRN Ms B] has identified that during her orientation/induction at [the rest home] she did not spend any time on the floor with an existing CSRN, only 3 days with ENs and 1 day with an RN, the other 4 days with the Clinical Coordinator and 1 day with the Educator and Human Resource person. The 'New Employee Orientation/Notification Form' shows she had 9 days buddied. Her 'Orientation Competencies Induction Checklist for R/Ns and E/Ns' seems to be fully completed and signed off on [the 29th of Month 3]. [CSRN Ms B] states in her performance appraisal held on [the 15th of Month 5] that she felt she was not fully orientated to her role. [Ms F], Care Manager, who completed the appraisal comments that it was 'unfortunate timing — can review it' but shows no evidence of this progressing further. [The rest home] has a responsibility to ensure its entire staff is fully orientated to their roles and I would have expected to see more discussion and perhaps a plan of action from this appraisal.

Review of Curriculum vitae reveals that [CSRN Ms B] probably has the necessary experience to build on for a position such as this but it appears she may not have been in a management position before. She identifies difficulties with staff in her appraisal and once again [the rest home] responsibility for training and support. The only option offered to her in her appraisal was to use the 'Poor work habits' form and refer to Human Resources or the Care Manager. In summary, it appears that [the rest home has] not ensured that [CSRN Ms B] has been fully orientated to her role and provided ongoing support for development.

Actions congruent with role and responsibilities

The Clinical Support Registered Nurse job description signed by [CSRN Ms B] on [the 23rd of the month prior to commencing her employment at the rest home] states, in part, the CSRN is to:

Key activity — Clinical support of nursing services
Give support to RNs and HCAs
Ensure professional nursing care is provided
Support to the family

Key activity — Clinical resource
Be responsible for obtaining reports from all areas at the start of their duty.
Be responsible for updating and keeping current care plans and records of Doctors' visits.
Act as a resource person for clinical staff.

Key activity — Clinical Practice
Indicates treatment in emergency and unstable situations.

It is very difficult to ascertain whether [CSRN Ms B] has achieved **all** the key activities outlined in her job description in the few months she was employed before this complaint was lodged. The job description is wide and varied and it must be taken into account that no performance issues were identified in her appraisal on [the 15th of Month 5] 2009. Perhaps the area of question I have is with regards to care planning.

She states that her responsibility lies in completing the rest home care plans, which is not in question here, and the RNs complete the hospital area care plans. However, I would expect that on the times that she reviewed [Mrs A] she updated her interventions in the care plan, for example the change in diet and fluids, push fluids and complete a fluid balance chart. The level of documentation evidenced from [CSRN Ms B] would be viewed with mild disapproval from colleagues.

3. Systemic factors impacting on ability to provide reasonable care and treatment

I am concerned that the workload that [CSRN Ms B] carried was overwhelming and unacceptable and this may have affected her in the issues above. I note that at the time of the complaint she was responsible for:

- providing clinical support to two hospital wings of 30 residents each
- a 30 bed residential area, supervising the practice of enrolled nurses and care planning responsibilities
- the Palliative care unit of 3 beds
- the wounds in her areas
- ordering of Bulk supply and controlled drugs for the whole facility and weekly stocktaking
- maintaining and organizing Special Authorities for the whole facility
- lead facilitator for implementation of LCP
- responsible for rest of facility on Thursday and Fridays, therefore the whole facility for those two duties

I also note that at the time of [Mrs A] becoming particularly unwell there was an outbreak of Norovirus in the facility. This meant that [CSRN Ms B] for the [29–31st of Month 6] was responsible for ensuring all measurements for management of this outbreak were implemented as well as carrying her usual workload. [The rest home has] a responsibility in this instance to ensure the outbreak is effectively managed as well as the usual day to day business of the facility. I see no evidence of extra support being provided for [CSRN Ms B] in this instance.

Also, having an office that was not adjacent to her primary areas of responsibility would not assist in effective time management, her ability to be readily accessible to on the floor staff or her ability to keep up to date with events.

Margaret O'Connor, RCpN, MN"

Further advice — 5 October 2010

Further comment was sought from Ms O'Connor in relation to adequacy of the rest home's systems and processes, and the extent to which the shortcomings were the result of individual or organisational failings.

On 5 October 2010, Ms O'Connor advised that the rest home's policies appear satisfactory. However, there were organisational issues — staff turnover, employment of inexperienced staff, and the use of bureau staff — which affected the service

provided. Ms O'Connor also queried whether the organisational structure ensured staff were provided with adequate support.

Further advice — 18 August 2011

Ms O'Connor was asked to review her advice in light of the responses to my provisional opinion and other information obtained subsequently.

"This advice is given in reply to the responses given by [the] Care Manager, on behalf of [the rest home] having read the findings from the provisional report. Information I have reviewed includes:

[Omitted for brevity]

In providing this advice I acknowledge [the rest home's] opposition to the 'overall responsibility/systemic issues' conclusions that have been drawn and have reviewed my findings taking into account the extra information that has been provided.

Professional standards and responsibilities incumbent upon nurses
I have acknowledged the responsibility of all nurses involved in [Mrs A's] care in regard to the NZNC competencies in my original report. Indeed, I agree that [the rest home] is 'entitled to expect all RNs in its employment to perform their duties strictly in accordance with those competencies'. However, as stated in my previous advice [the rest home] is also responsible for ensuring that they meet their contractual requirements regarding care provision. [The rest home's] quality processes should be able to identify any shortcomings in any area of service provision through the use of the quality cycle which includes auditing. I have reviewed the report from [the rest home's] Surveillance Audit which occurred just prior to the complaint period. This audit would have had a prearranged date as unannounced audits did not begin until [Month 10] 2009. It is important to note that the audit had no findings in the specific standards that were audited including Standard 1.3.5 — Planning.

Alleged systemic issues

a. Recruitment, orientation, training, and staff appraisals

i. Recruitment — I acknowledge the thoroughness of [the rest home's] processes in recruiting [CSRN Ms B] especially having had the benefit of observing her practice as an agency nurse.

ii. Orientation — [CSRN Ms B] has acknowledged that her 9 days orientation was spent with the Clinical Co-ordinator where she read policies while the Clinical Co-ordinator was in her office, three days with two ENs, a day with an RN and a day with the HR and Education people. She states that she did not spend any time with another CSRN, which could have been helpful.

Training — I acknowledge the clinical training provided to [CSRN Ms B] but question whether it may have been appropriate for the Care Manager to provide some training on staff management given the discussion that arose in [CSRN Ms B's] performance appraisal. [CSRN Ms B] said that she had brought up in her appraisal the

'issue of staff not following instructions and not reporting issues of concern' in [her area of the rest home]. She felt that the 'poor work habits' process was not appropriate in this circumstance therefore did not utilise it.

iii. Staff appraisal — [CSRN Ms B] states that she did not 'get any supplementary training or counselling from the Care Manager or HR Executive' and that they were both very busy and often in meetings when she went to see them. [CSRN Ms G] confirms this in her statement when she says '[Ms B] and I did not receive any clinical support from any of the other senior staff' naming the Educator, Care Manager and the Clinical Co-ordinator.

b. Other internal controls

i. 10am meeting with Care Manager — [CSRN Ms B] stated that she found the Care Manager was rarely available each morning to give a report to. *[This section has been redacted.]* It seems the CSRNs had the perception that the Care Manager was very busy, didn't like to be disturbed and at times was hard to locate. I note from the GM's email dated 26/5/11 that the 10am meeting was previously an expectation but now it is a clear requirement.

ii. Regular CQI meetings and monthly risk management meeting — [Ms F] states that [the rest home's] senior management had no visibility of [Mrs A's] condition, or the shortcomings in her care through this forum as [CSRN Ms B] did not seek intervention or advice in this forum. This perhaps highlights the issues in [the area of the rest home in which Mrs A was a resident] with the Registered Nurses' assessment of [Mrs A's] needs and subsequent planning of care, also the communication issues outlined in my previous report between the RNs and the CSRN. [CSRN Ms B] had informed the Care Manager in her performance appraisal that staff were not 'following instructions and not reporting issues of concern'. [CSRN Ms B] states that [the area of the rest home in which she was working] was being covered basically by outside bureau staff and a new RN. [Ms F] states that during the relevant period the permanent AM RN was on annual leave. I do note that the Manager's Report that is given to the Care Manager each morning, dated [the 30th of Month 6] does list [Mrs A] as being 'very unwell' on the afternoon shift.

Monitoring of Residents' Weights — According to the policy it is the Nurses', Caregivers' and Dietitian's responsibility to weigh and record weights. There is perhaps a lack of clarity around who is specifically responsible on what given day and who analyses and reports any loss/gain on the appropriate form. The pathway for reporting is clear.

i. Staff workload/support — [CSRN Ms B] has responded that she was 'responsible for the whole facility on most Thursdays and Fridays during the relevant period'. [CSRN Ms G] confirms this. However the Care Manager states at no time was [CSRN Ms B] in sole charge of 180 residents and that the Education Co-ordinator, [Ms O] was asked to work Thursday and Friday as a CSRN to cover the other areas. This is corroborated in previous documentation where [Ms F] states that to 'cover the shortfalls our previous and existing Education/Training RN person worked each Thursday & Friday as a CS in the clinical areas'. The General Manager also corroborates this in a recent statement. [CSRN Ms B] states that the Education Co-

ordinator only started at [the rest home] in [Month 3/Month 4, 2009] and was learning the Admissions Officer's job as well. [CSRN Ms B] says it would have been 'very unfair' to expect her to complete the clinical support role for two days and two other roles when she was relatively inexperienced and young. The General Manager has replied on 8.7.11 that [the rest home] 'strongly disagreed [with CSRN Ms G] that [Ms O] did not have the time or skills to assist as a CSRN'. He outlines that she had had 5 years postgraduate experience in appropriate settings for a role such as the CSRN and was offered these hours on the strength of her performance in her Education role. The discrepancies here aid confusion. The Care Manager obviously expected that [Ms O] would be the second CSRN on duty on Thursday and Friday mornings whereas [CSRN Ms B] has stated that she completed that role as well as her own. I do acknowledge [the rest home] senior structure for support when available however both [CSRN Ms B] and [CSRN Ms G] report that this was not always readily so. I also note that the Clinical Co-ordinator was away in USA at the time of the complaint, worked from home on Fridays and that position has now been disestablished (as of 13/1/10) and a third CSRN appointed.

ii. I acknowledge I have drawn wrong conclusions regarding [CSRN Ms B's] responsibilities in Norovirus outbreak. She was merely responsible for operations in the areas she was responsible for on the day not a co-ordination position for the whole facility.

iii. Palliative Care Unit — [Ms F] has said that [a hospice] employs a 'specific nurse' to look after the 3 patients in this unit 24/7. [CSRN Ms B] states that they are HCAs. [Ms F] says that the RN [in that area of the rest home] oversees day-to-day operations and [CSRN Ms B] has responded that because of the use of bureau nurses and a new RN in [the area] she undertook to oversee this area.

iv. LCP — [Ms F] states that the trial had not started at the time of the complaint and only preparations had begun. [CSRN Ms B] states that she and [Ms F] went to an interview for selection in the pilot but other than that she was the liaison person for [the DHB], completed the ongoing training and developed the LCP booklet. I note that planning work had been done involving [CSRN Ms B] prior to [Month 5] 2009. Also a pre-implementation audit had been completed for [the beginning of the year to Month 5] 2009. [CSRN Ms B] is noted to a have attended training on implementing LCP on [the 7th of Month 3].

v. Wound care — It appears that the CSRNs also completed any complex dressings in their area for their shift.

vi. Doctors visits —'[Ms F] has stated that in hindsight [CSRN Ms B] did not attend Doctors' rounds regularly even though the CSRN was expected to be there 'whenever possible'. [CSRN Ms B] has replied that Doctors' rounds were not always at the scheduled times and they often saw acute cases first and would then have no more time for rostered visits or they came when she was off duty.

vii. Controlled Drug check and ordering — [CSRN Ms B] states that it took her and another staff member approx 45 mins to do the CD check each week and half an hour to write up the order. Even less time was required to do the bulk supply orders.

[Ms F] expects this task took less time as she only signed requests for 4–5 entries at most for both orders.

Other factual matters

a) Handover — In my experience clinical staff have a responsibility to at least receive a verbal handover, check the ward diary and any communication sheets, read the notes/care plans for any resident having had a change in status and then view those residents and assess each shift. However, it is [the rest home's] responsibility to make its expectations clear during orientation and given that they have such a large number of foreign staff and bureau staff then I would expect they would not leave anything so fundamental unsaid. [CSRN Ms B] states she did not orientate with another CSRN so never saw reports being read nor the ward diary being checked. She also states she never saw her preceptor 'either read each resident's notes/careplans each day or speak to each resident and/or their family at least once or more each a day'. She states that clinical support at that time did not read the ward diaries but would go around each of the areas in the mornings and get a verbal report. CSRNs at this time were reliant on staff to verbally report any issues. [CSRN Ms B] states that now she has to visualize each resident in their areas and then read all the residents notes and the Ward Diary before getting a verbal handover.[32] [Ms F] has reported that an agency nurse was unable to contact [CSRN Ms B] and subsequently she did not read material in the resident's file or ward diary either. It appears the introduction of the new Service Summary sheet has enhanced communication between senior staff.

b) 'Nursing staff's responses can only be guided by the Doctor's assessment and diagnosis of severity of the patient's condition' — As the Care Manager pointed out previously in comments around nurses' competencies there is a nursing responsibility towards ongoing assessment of nursing diagnoses. Therefore there is an expectation that nurses will identify nursing issues and plan their responses accordingly. This can be separate to a Doctor's assessment but is in response to the presentation of symptoms.

c) I agree that 'shortcomings in the care delivered to [Mrs A] were so fundamental to the responsibilities of a Registered Nurse' but it is also [the rest home's] responsibility to ensure it meets contractual obligations and standards.

To summarise:

1) The revision of this information has succeeded in further highlighting previous concerns over communication at [the rest home] especially between the Care Manager and the CSRNs.

2) There seem to be discrepancies between what [CSRN Ms B] perceived her workload to be on Thursday and Friday morning shifts overseeing 180 residents care ([CSRN Ms G] corroborates this) and the Care Manager stating that the Education Co-ordinator was employed to work as a CSRN on these days, corroborated since by the General Manager. This conflicting information leaves a dilemma regarding what

[32] This was noted in CSRN Ms B's initial response to the complaint, at which time she was still working at the rest home.

the actual workload of [CSRN Ms B] was at the time of the complaint and what duties present and previous Education Co-ordinators completed on Thursdays and Fridays. I maintain that a workload such as [CSRN Ms B] has described previously on her Thursdays and Fridays at work where she was responsible for 180 residents may have been 'overwhelming and unacceptable', especially given the expectations of a CSRN that [Ms F] has outlined in her response dated 8 April 2011 page 6, points 16 and 17. To summarise from the information supplied to me by both the Care Manager and [CSRN Ms B], the CSRN was expected on each duty to:

a) be on site before 0700hrs to get a concise report from each area
b) read all ward diaries for [areas] responsible for
c) report to Care Manager at 1000hrs
d) read all residents notes and care plans in the areas of their responsibility
e) take care of any requests or cares that needed following up
f) 'visit each resident and speak with him/her (and family members if present) at least once or more each day'
g) attend all Doctors visits
h) complete the extra tasks that [CSRN Ms B] outlined previously including controlled drug checks and ordering, bulk supply ordering, care planning and wound care for complex wounds
i) [CSRN Ms B] also states she had responsibility towards LCP implementation and overseeing the Palliative care unit

The outlined workload would have been far more achievable for 90 residents. It is perhaps important to note that [the rest home has] now restructured and disestablished the Clinical Co-ordinator position and employed a third full-time CSRN.

3) I remain confused as to the role of the Clinical Co-ordinator in relation to the CSRN and the Care Manager.

4) Believing some tasks are so fundamental that they 'go without saying' is perhaps not a healthy attitude when you have obligations to meet in care provision. Employers have a responsibility to ensure staff are aware of their expectations for their performance and this is usually outlined during orientation and ongoing training.

5) All registered nurses are responsible for ensuring they meet the required competencies of their practice. Service providers are responsible for ensuring they meet their contractual obligations and the relevant standards. We have already established that both parties have failed to do this in providing care to [Mrs A].

Margaret O'Connor, RN, MN"