Nurse Manager

A Rest Home

A Report by the

Health and Disability Commissioner

Case 01HDC13272

Parties involved

Mrs A	Consumer
Mrs B	Complainant, Consumer's daughter
The Private Rest Home	Provider
Mrs C	Nurse Manager, The Private Rest Home
Public Hospital	Provider
Second Public Hospital	Provider
Dr D	General Practitioner
Dr E	GP records
Second Private Rest Home	Provider
Ms F	Staff Nurse, The Private Rest Home
Mr G	Consumer's nephew
Mrs H	Consumer's nephew's wife
Ms I	Social Worker
Nurse J	Registered Nurse
Dr K	General Practitioner
Dr L	Clinical Director, Older Person's Health Service, District Health Board

Complaint

On 15 November 2001 the Commissioner received a complaint from Mrs B about the care that her mother, Mrs A, received from a Private Rest Home. The complaint was summarised as follows:

The Rest Home
The Rest Home did not provide services of the appropriate standard to Mrs A while she was receiving respite care at the Rest Home from 9 to 23 April 2001. In particular it did not ensure that:

- *Mrs A was assessed by a doctor when she was admitted.*
- *Mrs A was appropriately examined and treated following falls.*
- *The injuries suffered by Mrs A following falls were appropriately documented.*
- *Mrs A received appropriate medical treatment when her health deteriorated prior to and during the weekend of 21 and 22 April 2001.*
- *The plan suggested by staff at the Public Hospital was followed. This plan was made to ensure Mrs A's safety at the Rest Home during the weekend of 21 and 22 April 2001 preceding her arranged admission to the Public Hospital on 23 April 2001. Mrs A was later admitted from there to another Public Hospital in a seriously ill state.*
- *The plan suggested by staff at the Public Hospital was appropriately documented.*

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- *Arrangements were made for Mrs A to be taken by ambulance or by some other appropriate means to the Public Hospital on 23 April 2001, as at that time she was partly unconscious and badly dehydrated.*

Mrs C

Mrs C, Nurse Manager, Rest Home, did not provide services of the appropriate standard to Mrs A while she was receiving respite care there from 9 to 23 April 2001. In particular she did not ensure that:

- *Mrs A was assessed by a doctor when she was admitted.*
- *Mrs A was appropriately examined and treated following falls.*
- *The injuries suffered by Mrs A following falls were appropriately documented.*
- *Mrs A received appropriate medical treatment when her health deteriorated prior to and during the weekend of 21 and 22 April 2001.*
- *The plan suggested by staff at the Public Hospital was followed. This plan was made to ensure Mrs A's safety at the Rest Home during the weekend of 21 and 22 April 2001 preceding her arranged admission to the Public Hospital on 23 April 2001. Mrs A was later admitted from there to a second Public Hospital in a seriously ill state.*
- *The plan suggested by staff at the Public Hospital was appropriately documented.*
- *Arrangements were made for Mrs A to be taken by ambulance or by some other appropriate means to the Public Hospital on 23 April 2001, as at that time she was partly unconscious and badly dehydrated.*

An investigation was commenced on 6 May 2002.

Information reviewed

During the course of my investigation I carefully reviewed information from Mrs B, the Public Hospital, the Second Public Hospital, the Ministry of Health, Dr D, Dr E (GP records), Mrs C, The Rest Home, Ms F, the Second Rest Home, Mr G and Mrs H.

I also received independent expert advice from Ms Jan Featherston, a registered nurse specialising in the care of the elderly.

Information gathered during investigation

Background
Mrs A, aged 79 years, was admitted to the Second Public Hospital with delirium, hallucinations, and dehydration on 2 February 2001 from the Second Rest Home where she was receiving respite care. She was transferred to the Public Hospital on 19 February, and discharged home on 20 March 2001.

On 9 April 2001, Mrs A arrived at a ward at the Public Hospital, believing that she was due for admission. No admission had previously been arranged. The service co-ordinator on the ward at the Public Hospital assessed Mrs A as requiring care need level 2, which meant that she required general rest home care. Accordingly, she arranged by telephone for Mrs A to be admitted to the Rest Home for 14 days' respite care.

Information provided on admission to the Rest Home
Mrs C, Nurse Manager at the Rest Home, alleged that the Rest Home did not receive sufficient information about Mrs A's psychiatric history when she was admitted. She acknowledged that the Rest Home received a copy of Mrs A's Care Needs Level Assessment. This included information that Mrs A was able to manage most of her self-cares independently and that she had some short-term memory loss or confusion which did not restrict her daily living, apart from management of her finances. The information noted that Mrs A needed encouragement with her food intake and was a fussy eater. The Rest Home recorded on the admission information sheet that Mrs A required respite care as she was unable to cope at home.

The service co-ordinator advised me that, in addition to the information in her assessment, she informed the Rest Home that Mrs A had not been managing at home recently, had become confused and had issues surrounding her eating.

The Rest Home advised me that the admitting doctor usually listed the medical diagnoses or problems in the medical notes. This was not completed in this case because Mrs A was not assessed on admission, for reasons discussed below. Mrs A was admitted without a management plan or documentation from a doctor about the correct dosage of her medication.

Mrs C provided me with a copy of the Rest Home's Service Specification Agreement for Respite Care for Aged Related Support Services, dated 8 July 1998. The agreement states that in offering respite services, the service will provide any additional input the care plan indicates is required, and initiate early treatment of acute illnesses or exacerbation of chronic health problems and reduce the need for increasing support and ongoing support services by referring the client on to their service co-ordinator or GP, as relevant. Each client admitted for respite care is to have a written and implemented care plan.

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Initial assessment by a doctor

Dr D had been Mrs A's GP for several years, even though he practised on the other side of town from where she lived. Mrs A refused to see any doctor who practised closer but eventually her care was transferred to a local medical centre (this transfer is confirmed by Dr D). However, Mrs A was admitted to the Rest Home prior to being assessed by a doctor from the medical centre. Mrs B (Mrs A's daughter) said that she suggested the house doctor admit her mother, but the Rest Home "dillied and dallied".

Mrs C acknowledged that Mrs A was not assessed by a doctor on admission. In a letter to Mrs B dated 16 June 2001, Mrs C stated that for any admission, whether for a few days or long term, it is normal procedure to have that person assessed by a doctor within 24 hours and whenever necessary after that. This was reflected in the Rest Home's admission policy at the time. Mrs C also stated that the Rest Home did not require residents admitted for respite care to be routinely assessed by a doctor if their medication was clearly documented and sufficient information was provided (which was not the case for Mrs A).

Mrs C said that on admission the Rest Home discussed the issue of Mrs A's general practitioner with Mrs B and the service co-ordinator, and explained that Dr D should not be contacted because of past difficulties. Ms F, a staff nurse at the Rest Home, confirmed this account. The admission information sheet also records: "advised by Ms I [social worker] not to ask Dr D". Mrs C also said that Mrs A did not wish to see the house doctor and that a doctor from the medical centre did not feel it was appropriate to visit as she had not met Mrs A. Mrs C stated that between 9 and 19 April the Rest Home constantly communicated with Mrs B and the service co-ordinator in an attempt to arrange a suitable doctor to assess Mrs A, without success.

Mrs C advised me that, to prevent this problem from recurring, the Rest Home has altered its admission procedure and now requires that the house doctor assess patients admitted for respite care if their GP is unable to assess them within 24 hours.

Deteriorating condition

During her stay at the Rest Home, Mrs A's condition significantly deteriorated. By 17 April Mrs A was very confused and delirious, and had still not been assessed by a doctor. The Rest Home became concerned about Mrs A's eating and behaviour and, on 17 April, discussed her health status with the service co-ordinator. The service co-ordinator's notes record that Mrs C was concerned because Mrs A was not eating, was confused, was not walking, and had had a fall. It was also noted that Mrs A was difficult to cope with.

On 18 April, Mrs C phoned Mrs B to advise her that Mrs A had deteriorated markedly.

Needs assessment

The service co-ordinator visited and assessed Mrs A on 19 April 2001. Mrs C alleged that the service co-ordinator said Mrs A should return home after her two weeks' respite care. However, the service co-ordinator's notes indicate that after assessing Mrs A, she was concerned about her poor mobility, inability to answer questions, and bruising due to falls,

and agreed that she required supervised care. The service co-ordinator discussed with Mrs A permanent placement in a rest home, but agreed that in the meantime she should be admitted to hospital.

Mrs C stated that she informed the service co-ordinator that if Mrs A could not be admitted to the Public Hospital, then the Rest Home would send her to the Emergency Department at a second Public Hospital. Arrangements were made for Mrs A to be admitted to a ward at the Public Hospital on Monday 23 April, when a bed was due to be available. The service co-ordinator recorded in her notes that she phoned Mrs C on 20 April to advise her of this, and that Mrs C would arrange transport to the hospital. Mrs C stated that she informed the service co-ordinator that Mrs A needed to be admitted before the weekend.

The service co-ordinator recorded in her notes that she informed Mrs C that if there was any further deterioration in Mrs A's condition over the weekend, she was to contact the Psychiatric Service for the Elderly duty district nurse. The service co-ordinator made Mrs A's file available to the duty nurse over the weekend. Mrs C could not recall being given these instructions by the service co-ordinator, and the instructions were not recorded in Mrs A's Progress Notes.

Medical assessment
Due to the difficulty with finding a GP to assess Mrs A, the Rest Home contacted Mrs A's former GP, Dr D, who agreed to assess Mrs A on Friday 20 April 2001. Mrs C hoped that Dr D would admit Mrs A to hospital before the weekend, but he did not.

Dr D was not concerned about Mrs A's general condition, but he did not think that the Rest Home was the appropriate place for her. After the consultation he rang the Public Hospital and requested that Mrs A be removed from the Rest Home, as he did not think that the Rest Home wanted to cope with her or that she fitted within their criteria.

In a letter to Mrs B dated 29 June 2001, Dr D stated that he believed Mrs A was due to be transferred to the Public Hospital on 20 April 2001. He understood that after his visit, a decision was made not to send her to hospital until after the weekend.

The Rest Home advised me that Dr D informed the Rest Home that he believed all that could be done for Mrs A was being done, and the arrangement that she be admitted to the Public Hospital on the Monday was satisfactory.

Mrs C stated that she was not on duty on the weekend of 21 and 22 April, but she rang the Rest Home over the weekend to check on Mrs A's condition, which did not deteriorate over the weekend.

Falls and assessment
The Rest Home has a policy for Incident Reporting, stating that all incidents will be identified, documented, evaluated, and corrected by the staff member involved, Senior Nurse and/or Management. Specifically, the policy requires staff to:

- take immediate action to ensure safety and minimise further harm when an incident occurs
- advise a senior staff member and/or management as soon as possible
- contact the appropriate doctor, ambulance or police, if necessary
- document details clearly and accurately on an accident and incident form, and in the resident's progress notes
- notify the next of kin if the incident is serious, and document this in the resident's progress notes.

The Policy also states that Accident and Incident forms will be evaluated monthly to assess and identify any risk areas or patterns that emerge, and to identify the action to take to correct or minimise the risk or recurrence.

On 18 April 2001 Mrs A fell while in the bathroom. Her notes record that she was found lying on her left side, and that she had slight bruising on her left cheek. She was assessed by staff and observed for 24 hours, but was not checked by a doctor. Mrs C informed me that Mrs A made it clear that she did not wish to be assessed by the House Doctor, or her current doctor. An Accident and Incident form was completed, and the fall was noted in Mrs A's progress notes.

Mrs A had two more falls on 19 April, which were noted in her progress notes, and one Accident and Incident report was completed for both falls. Another fall was documented in Mrs A's progress notes on 20 April, and an Accident and Incident form completed. After Mrs A's third fall Mrs C asked Dr D to assess Mrs A, because she wanted to investigate the reasons for Mrs A's falls.

Mrs B complained that by the time of Mrs A's discharge on 23 April, she had severe bruising all over the left side of her face and body, and pain in her spinal area.

Transfer to the Public Hospital

Mrs C said that on 23 April she phoned Mrs A's nephew, Mr G, to tell him that she was sending Mrs A to the Public Hospital by ambulance, but he arrived before the ambulance had been arranged and offered to take her himself.

Mrs B complained that an ambulance was not offered to Mr G to transport Mrs A to the Public Hospital on 23 April. Instead, he was left to carry her out of the Rest Home and transport her to hospital in a semi-conscious state. Mr G confirmed this, advising me that the Rest Home did not discuss with him the option of transferring Mrs A via ambulance.

Mrs A's progress notes record: "As noted [Mrs A]'s condition is frail so d/w [discussed with] Mr G re ambulance transfer but as he was here he thought he could manage."

The District Health Board (DHB) advised in a letter dated 24 September 2001 that under section 30.1 of the Health and Disability Services Agreement for Rest Homes, it is the

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responsibility of the Rest Home to ensure that ambulance services are available to acutely unwell residents.

Admission to Hospital
Mrs A was transferred acutely from the Public Hospital to a second Public Hospital on 24 April 2001 with a reduced level of consciousness, and hypercalcaemia secondary to medication. Her bruising was noted on admission.

Independent advice to Commissioner

Mrs Jan Featherston, a registered nurse specialising in the care of the elderly, provided the following independent expert advice:

"**History**
[Mrs A] was a lady who was admitted to [the Second Rest Home] on 12th January 2001 for respite care. While she was at [this Second Rest Home] her health deteriorated and she required admission to [the Second Public] Hospital .

[Mrs A]'s admission problems were listed as Delirium ? cause, Dehydrated, shingles, pneumonia, etc. [Mrs A] was treated and transferred to [the Public Hospital].

The Clinical notes from there indicate that [Mrs A] continued to have problems with food and fluid intake, still had confused thoughts and tended to isolate herself from others. She was discharged home on the 20th March 2001. The clinical notes indicate that [Mrs A] did not cope at home and was admitted to [the Rest Home] on the 9th April.

Admission

Was [the Rest Home] provided with adequate information about [Mrs A's] condition and medical history prior to her admission? If not, what information should have been provided?

The information that was supplied to [the Rest Home] consisted of the faxed letter from the [service co-ordinator] and a copy of the Care Needs Level form. This form is four pages long and consists of the front sheet which identifies the resident, lists the date of assessment as the 13/03/01, who carried out the assessment ([Nurse J]) and the service coordinator, the care need level which was identified as 2, the type of service was listed as Psychiatric.

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Page two to four lists the assessment in relation to the activities of daily living. This area has five options from which to choose from the assessment that has been done, with the nurse circling the most appropriate.

There is a comment under each of the headings:
Eg Self Cares
'Can manage most activities herself but tires easily and often has to rest after showering and dressing. Needs someone else to cut nails and apply lotion on her back and wash hair. Needs encouragement with food intake, fussy eater.'

Mobility
'*Mobility satisfactory for short distances and moving about indoors for long distances would need wheelchair or be driven*.'

Continence
'Has frequent episodes of urine incontinence but only small amounts. Also able to use toilet independently. Needs to be supplied – pads.'

Sensory/Communication
'*Clear explanations necessary.*'

Memory loss/Confusion
'*Has some short term memory loss so need to write things down, but this does not restrict her daily living, apart from managing finances*.'

Page four lists the assessment need as 2.

This assessment indicates that [Mrs A] was reasonably independent and although she had short-term memory loss it did not affect her in her activities of daily living.

The assessment does not identify in any way the confusion and paranoid thoughts that [Mrs A] had experienced in hospital. The assessment was also undertaken on 13/3/01 while [Mrs A] was in hospital. It would appear to paint a different picture from the clinical notes that were written about her at that time. She was identified as having limited food intake and there were concerns around that. Also the level of pain, and assistance that was required for her to bath and shower.

Following her discharge home she was followed up in the community. The clinical notes have entries in them dated 21/3/01, 27/3/01 – states *'New GP not yet arranged'*, 30/3/01 – this entry states, *'Has been to [Dr K].'*

On 5/4/03 [Mrs A] arrived in the ward. The clinical notes state that she was somewhat muddled. Respite care was suggested for 14 days.
6/3/01 Discussion with [Mr G] re admission to [the Rest Home] on Monday.

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All of these entries are signed by [the service co-ordinator].

There is no documentation to state that there was a verbal handover to the nursing staff at the Rest Home.

It is my opinion that the information supplied to [the Rest Home] was inadequate for staff to get an accurate picture to plan care.

Information that would have been helpful would include:

- Social and Psychiatric history about [Mrs A]
- Discharge letter from the medical staff following her discharge on 20 March. It would obviously not have been addressed to the Rest Home but a copy of the discharge letter sent to her GP. ([Dr D] was listed on stickers from the hospital).
- A full explanation of the medical events, and admission and discharges that [Mrs A] had had since the beginning of the year.
- Full list of next of kin with phone numbers
- The GP that was to attend to [Mrs A]

Policies and Procedures

The policies and procedures that [the Rest Home] had at the time related to all general admissions to the facility. They covered what the facility was required to have in relation to 'getting ready' for a resident.

The 'Guidelines' outline that residents will be made aware of their rights and responsibilities, an information booklet will be given to the resident, and all necessary information collected to aid admission.

The policy goes on to include what documentation was to be completed on admission, including advising the kitchen of meal requirements. It states that the resident may keep their own GP or use the services of one of the resident doctors. It states that medications must be handed to the RN and that medication must be prescribed by the admitting GP and documented on the Medication order sheet.

The admission document notes the Health and Disability Code of Rights, the Privacy Act, Advocacy Service, Complaints policy/ procedure.

The admission policies, although brief, do cover the necessary requirements. I did not sight a consent form, which I think would have been used. I have not sighted the contractual arrangements with the local funding authority but in general these policies would have been fairly typical of rest homes and would in my opinion have been acceptable at the time.

It is noted that [the Rest Home] did not have policies to cover respite care. It is also not noted whether the facility provided respite care on a regular basis. It would have been expected that the facility would have had appropriate policies to deal with respite care. These policies would have outlined the service that the facility was expected to give.

Respite care can either be a 'one off' or done on a regular basis, in that the same person can come back say every 4 months for a week, to give the family a break. If that is the case then the requirements can be quite different to a full time admission. Only a short-term care plan may be required. This would identify short-term goals and it may not have been necessary for the GP to see residents if, say, they had seen them the week before and their health was good.

[Mrs A] did not present like this and hence the policies would appear limited.

Present polices

The undated policies that are presented with the documentation are adequate to meet the needs of the residents and meet the standards. Consideration should be given to only accepting a resident for respite care if a letter from the resident's GP is received outlining the medical condition and a plan of advised care for the time the resident is to spend in the facility. This may be acceptable from the community nurse or needs assessor. This will identify who the GP is and who will be responsible for the medical care. It also gives the facility a base line to work from.

Doctor

It would have been common practice for a routine respite resident to be cared for by that resident's GP in the community. To use the facility GP to cover for a week or two would not be practical in that they would have to transfer medical notes, etc over. Most residents have a GP in the community and it is my experience that they are willing to continue to provide care while the resident is in respite. This allows for the GP to have a good knowledge of the conditions and the state of health prior to admission. They would certainly be able to identify if the resident deteriorates and can advise the nursing staff of an action plan based on prior knowledge.

It would have been acceptable for [the Rest Home] not to arrange a visit by a GP to routinely assess residents receiving respite care if there was sufficient information and medications that were clearly documented. Also it must be noted that the GP would be able to be contacted by phone.

However this was not the case with [Mrs A]. She did not come with adequate documentation in relation to her needs nor in relation to the medications. To arrive only with a blister pack would in my opinion not be acceptable. I note that the staff contacted

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the pharmacy that dispensed the pack and then contacted the doctor who appears to be [Dr K]. [Mrs A] refused to see him.

In my opinion the delay was not acceptable. In a resident who had deteriorated it would appear obvious to staff that this person was quite different from the needs assessment documentation that the facility had received. In saying that, there was evidence that the staff had attempted to locate and find out who [Mrs A's] doctor was.

It is identified in the clinical notes from 27/03/01 – '? New GP not yet arranged'. This is signed by [the service co-ordinator].
On the 30/03/01
'Has been to GP Dr [I]'.
This information was not documented in any correspondence given to the Rest Home.

Falls

The first fall occurred at 7.50am on 18/4/01 when staff found [Mrs A] on the floor of the bathroom. The progress notes state that '? Whether she had fallen or slipped off the shower chair.'

Staff wrote: 'NAD (which stands for no abnormalities detected) when checked over – slight bruising face L cheek.'
'ROM (stands for: range of movement) satis weight bearing satis. Pain Nil c/o voiced assisted by 2 staff to walk thu to chair in room. A little shaken – Reassured incident form.' This entry is signed and RN is documented beside the name.
There is also an entry in the resident care plan dated 18/4/03, which states:
'Observe falls'
Accident /incident report was completed
This included a description of the accident
The extent of the injuries
The treatment given
There is the name of the nurse filling out the form.
The follow up was documented on 19/4/01: 'Appears satis
20/04/01 – Bruising still evident L cheek.' Both these entries are signed.

The progress notes for the PM shift state what care [Mrs A] received that evening. On 19/04/03 the notes state:
'Not well am ref to get up. Up by lunchtime call into [Dr D] re assessment – He will ring back pm. Also to [service co-ordinator] re [Mrs A]'s condition.'

1330hr 'SB [service co-ordinator] – who will D/W team re [Mrs A]'s placement. [Dr D] rang – may see [Mrs A] tomorrow am.'

That evening [Mrs A] fell twice. Each fall is not documented. The progress notes state: 'Fell x 2'.

Staff have documented that [Mrs A] is very unmotivated and confused, and that during this shift her nephew visited her.
One incident form has been used to document both falls, it gives a description of the accident.
It lists the extent of the injuries as NAD (means – no abnormalities detected).
It outlines the treatment given and is signed by the nurse.

The fall on the 20th occurred in the evening. It is documented that staff found [Mrs A] on the floor. It states she appears fine. Incident form was ticked. The incident form outlines a description of the accident. The extent of the injuries is listed as NAD. The treatment given is listed. The form is signed.

The documentation is adequate but in my opinion not best practice. The incident on the 18th was well documented in the progress notes in that it identifies what examination was carried out and what assessment the nurse made. The other falls were briefly documented, although they do not go into depth in relation to a physical examination. There were no recordings taken, such as a lying and standing blood pressure, whether [Mrs A] was febrile, what could have caused the increasing confusion, etc.

It is noted that the staff did attempt to contact the Doctor and were advised that he would visit the next day.

Dr assessment following falls

It would appear from the documentation of the staff's assessment following each fall that there were no abnormalities detected. It is noted that staff did attempt to contact the doctor on the 19th and the doctor visited on the 20th. This was following three of the falls. As previously mentioned the staff could have carried out a more thorough physical assessment. Staff could have called an on-call Doctor but there is evidence that [Mrs A] did not want to be seen by the resident doctors. The resident has the right to refuse, which it appears she did, but it certainly leaves the nursing staff and the facility open to review.

[Dr D] saw [Mrs A] on the 20th April. His notes document that she was confused to day, month and year. He states she can't walk unaided and can feed herself, needs help c/o dressing and mobilizing, needs constant supervision as she falls and has bruising ???? She now is at the stage of needing full time care and this will not change. (Parts of the notes are difficult to read.)

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It would appear from the medical documentation that [Dr D] did not complete a physical assessment on [Mrs A] and there is no documentation of any base line recordings such as temp, pulse, blood pressure.

Adequacy of the procedure for incident reporting dated August 2000

There are two forms in relation to incident reporting. The Policy outlines the definition, the policy, the policy guidelines, training and education and reference. Page two is the procedure that one would take in the event of an incident.

The policy and procedure is adequate but not best practice. It does state that all incidents will be identified, documented, and evaluated by senior staff. A corrective action plan will be implemented.

What needs review is that the policy states that incidents are evaluated monthly and results are evaluated monthly. This time frame is too long if a resident has an acute episode and has a number of falls or incidents in a short space of time. What would be recommended is that residents who fall and subsequently fall in a very short time frame are listed as 'alert' and an action plan is put in place to identify what has caused these incidents. This alerts senior staff to carry out an in-depth assessment. It also ensures that the events are well documented, and reported to medical officers, etc. Overall the policy and procedure is adequate.

Care

Did [Mrs A's] condition deteriorate while she was at [the Rest Home]? If so, did staff appropriately manage her deterioration?

The information presented by [the Rest Home] in relation to documentation on [Mrs A] was:
Admission information form
Progress notes
Resident care plan drug administration sheets
Incident forms
Medical notes

The resident care plan indicated that [Mrs A] was independent with supervision in most activities. There is no date as to when the resident care plan was first documented.

The progress notes were commenced on the date of admission 9.4.01. The entry states that she was independent with most care – some supervision may be needed. It does state that [Mrs A] was 'very tired'.

She appears to have slept well and no problems were identified on 11.4.01. On 12.4.01 the entry identifies that [Mrs A] 'Complained of nausea at lunch? Cause transferred to her room via wheelchair Lactulose gn am observe? BO'. This is the first indication that [Mrs A] was unwell. The entries from then on indicate that [Mrs A's] condition deteriorated. In that she became frail and rested on her bed, she felt unwell and the problem with nausea continued. The progress notes state that she was confused. Staff states on 16.4.01 'Unwell am? Cause Temp 36.1 BM 5.4 Pulse status confused at times but up for meals. Very incontinent of urine.'

Also on that day she went out for a drive. The notes do not indicate whether this was with family or on an organized tour. One can assume that at that stage she was well enough to go out. That afternoon she remained confused.

On 17.4.01 staff reported that she was very unmotivated.

Again on 18.4.01 the notes indicate that she was suspicious of others not taking medications and at that stage [Mrs A] had her first fall.

The resident care plan has four entries listed in the Acute Short term orders. These are listed as:
12.4.01 – Nausea observe
13.4 01 – Anxiety Reassure
17.4.01 – Poor motivation – encourage and assist
18.4.01 – Observe falls

Certainly from 18.4.01 [Mrs A's] condition deteriorated. She remained in bed, refused medication and food. She fell again twice on 19.4.01.

The progress notes indicate that staff were aware of [Mrs A's] condition. They appear to have identified the problems as they arose as they were listed in the resident care plan. The progress notes indicate that staff did attempt to assess [Mrs A's] condition. They took recordings on 16.4.01. They attempted to get a urine spec from her and staff assisted to feed her. The notes indicate that staff were very concerned on 19.4.01. They attempted to contact [Dr D] and the [service co-ordinator] who had arranged [Mrs A's] placement. The [service co-ordinator] visited on the afternoon of 19.4.01 and [Dr D] arranged to see [Mrs A] on 20.4.01.

Notes indicated that [Mrs A's] condition remained very frail from 19.4.01 onwards.

In my opinion [the Rest Home] acted appropriately in that they called the health professionals that knew [Mrs A]. [Dr D] visited and his notes do not indicate a full medical assessment was undertaken. The nursing notes and documentation would have been available from him to review. It is my view that a more thorough assessment by [Dr D] may have indicated an admission to hospital at that stage. One can assume that

he was not overtly worried and felt that the Rest Home was able to give adequate care despite staff expressing concern. Admission was made for Monday morning and this would indicate that both the [service co-ordinator] and the doctor felt that [Mrs A] would not deteriorate further. The statement made by [Mrs C] to the HDC on the 10 June (page 3) indicate that [the Rest Home] was told that there were no beds available and that the admission would have to wait till Monday.

Did staff provide adequate care during the weekend of 21 and 22 of April?

The progress notes indicate that on the morning of 21.4.01 [Mrs A] had a shower and a hair wash. She was able to sit up in the chair but refused to eat her meals. She was not initiating any cares which would indicate she was frail. It appears she spent most of the day resting on her bed. The PM shift entry states that she was dribbling food from her mouth and needing encouragement with fluids. On 22.4.01 she sat up in the chair in the morning, and again refused lunch. The entry states she was very low and unmotivated. The PM shift states that her condition remained unchanged and that she continued to spit food out.

The question is a difficult call as the progress notes indicate that staff did attempt to feed and offer [Mrs A] fluids. Staff indicated that they attended to her personal care. It must be recognised that the elderly who do not eat and drink will deteriorate much more quickly then a younger person. Also with poor food and fluid her mental state would deteriorate. It is my opinion that staff should have sought medical intervention but it is understandable why they did not as they were aware that [Mrs A] would be admitted on the Monday.

Overall did [the Rest Home] provide services of an appropriate standard to [Mrs A] during her respite care?

In reviewing the care one looks at the progress notes and the care plan to assess what assessment and intervention the facility provided. The care plan listed the level of independence, the problems and the objectives of care, the interventions were listed and divided into three shifts – morning, afternoon and night. This section was completed for the Activities of Living including:
Eating and drinking
Eliminating
Personal Cleaning and Dressing
Mobilising
Sleeping
Controlling Pain
Communication
Working and Playing
Maintaining a Safe Environment

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Acute short-term problems was a section that staff would have contributed to as problems arose. They are listed as:
12.4.01 Nausea
13.4.01 Anxiety
17.4.01 Poor Motivation
18.4.01 Observe Falls

The format used for the resident Care Plan is one that is used by many Rest Homes. It is nationally accepted as meeting the requirement for care. [The Rest Home] completed this adequately. This care plan would be very typical of what one would find in aged care rest homes. In fact many care plans are not completed until after the resident has been in the facility for a month.

Best practice would have included a short-term care plan to expand on the short-term problems that the facility identified and a daily evaluation of care. Also it is noted that there were no base line recordings taken or if there were, they were not provided in the documentation. There are recordings taken during the stay and these are written in the progress notes.

Overall it is my opinion that the care provided was adequate.

Admission to Hospital on 23 April 2001

It is my view that [Mrs A] should have been transported to hospital by ambulance. The progress notes indicate that staff had discussed this with family and they indicated they could manage.

Medication

In what way if any would her non-compliance with medication have affected the management of her condition?

The rest home have submitted the signing sheet for non-packaged or PRN administration Record. There is no documentation as to what medication [Mrs A] was admitted with. One can assume that the medications were the medications she was on when she was discharged from hospital. There was a script dated 20.3.01.

Medications are listed as:
Frusemide 40 mg 1 in morning
Allopurinol 100mg one in morning
Calgtriol .25mg 2 in morning
Thyroxine 50 mg 2 or 3 tabl alternate days
Aspirin 300gh ½ in morning
Calcium Carbonate 1.5ng one twice a day

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Paracetamol 500mg 2 four times a day
Combivent inh one puff four times a day

When required – Lactulose

In assessing the medication sheets two copies were presented with the documentation. One was faxed on 11.3.03 and one was presented with documentation from [the Rest Home]. The faxed copy outlines when [Mrs A] refused to take her medication and the other only has an 'R' on 23.4.01. The faxed copy lists 7 times when [Mrs A] refused to take her medications. The progress notes list 18.4.01 as the first time that [Mrs A] refused to take her medications. There is an entry on 18.4.03 stating 'Supervise with medications.' The next entry is on 23.4.01 when the entry states 'refused all medications.' There is a conflict in charts. It appears that 'R' has been written in since the original copy was sent to HDC.

This is very poor practice in that there is no accurate recording of when [Mrs A] did refuse her medications. The second chart does not coincide with the progress notes. It is impossible to form an accurate picture of when [Mrs A] refused her medication.

The documentation in the progress notes could indicate that [Mrs A] refused one more than the seven times, as feeding was difficult. If [Mrs A] had refused her medications on a very limited number of occasions then the effect would not have been great. But if she refused or spat out medications frequently and especially in the morning, which is when she took most of her medication, then the effect would have been far greater. I am not qualified to give a pharmacology opinion on that issue.

Did staff appropriately manage [Mrs A's] refusal to take her medication?

As previously stated I do not think that staff managed the medication dispensing professionally. There must be accountability in administering medications. [The Provider] is a Rest Home and does not have to have a registered nurse on site at all times. There is no designation on the drug-dispensing sheet to indicate what role the staff had when administering the medication. Also it would have been appropriate to have the drugs charted. I acknowledge the issues with the doctors.

General

It is my opinion that this is a sad case of lack of communication with the public system and the private provider. [Mrs A] was a complex resident who required a high level of care. To place her in a rest home for respite care may have been appropriate but not to provide the support and information that the facility needed to manage her was in my opinion setting them up to fail. The Rest Home should have been given adequate information such as her previous respite care admission, which also required admission to a public hospital as well as her progress in the public hospital. The information

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should also have included an accurate updated list of next of kin. When the staff at the facility contacted the medical officer and the [service co-ordinator] there did appear to be a real lack of intervention on their part despite them visiting. It was obviously their opinion that the facility could cope until the Monday. The staff at [the Rest Home] did document that they had requested assistance and had identified that [Mrs A] was deteriorating. Rest Homes are not geared nor do they have to have the trained staff to provide acute level of care, although there is an expectation that they will.

[The Rest Home] staff acknowledge that in retrospect they should have admitted [Mrs A] to A+E or at the least ensured a visit from their resident doctor even if [Mrs A] had refused to see them. [The Rest Home's] documentation system, although adequate, certainly was not best practice in relation to administration of medications."

Responses to Provisional Opinion

Mrs B

In her response Mrs B noted that she was pleased that the Rest Home had changed its admission procedure to ensure residents are assessed by the house doctor on admission if their general practitioner is unable to do so within 24 hours.

Mrs B commented that she and her sister were concerned about their mother's deteriorating condition over the weekend of 21 and 22 April because of telephone calls they had made to her. Mrs B said that staff at the Rest Home should immediately have requested additional medical assistance or contacted the duty district nurse from the Psychiatric Service for the Elderly as the service co-ordinator had instructed. Mrs B also said that if staff at the Rest Home were unclear about her mother's medication when she was admitted, they should have contacted medical staff at the Public Hospital for clarification.

Mrs C

In her response Mrs C acknowledged my recommendation that the Rest Home develop and implement specific policies for respite care and noted that it has done so. She acknowledged my recommendation that the Rest Home review its policies and procedures concerning the reporting and evaluation of accidents and incidents and stated that they have been amended accordingly.

Mrs C also said that the Rest Home had amended its policies and procedures concerning the administration of medication, to ensure that all staff understood the significance of documenting a resident's refusal to take medication.

Mrs C commented that the Rest Home had met its obligation under section 30.1 of the Health and Disability Services Agreement for Rest Homes to ensure that, in view of Mrs

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A's acute condition, an ambulance was available to take her to hospital. However, Mr G had taken the matter out of the hands of staff by insisting he take Mrs A to hospital in his car, even though they tried to persuade him otherwise.

The District Health Board

A response on behalf of the District Health Board was made by Dr L, Clinical Director, Older Persons' Health Service. Dr L advised that, at the time of Mrs A's admission on 9 April, the service co-ordinator provided the Rest Home with information about her in the support needs assessment and care needs level assessment forms. Dr L advised that the Board was not required to include medical information in these assessments but that the Older Persons' Health Service was working toward the implementation of a comprehensive geriatric assessment programme to ensure that assessments will take into account both the health and disability issues of frail older people (and that as a result more information will be available to carers). He advised that the Health of Older People Strategy contains the necessary framework for this change.

Dr L also acknowledged that it would have been advantageous if the Rest Home had been provided with the discharge summary letter regarding Mrs A's admission to the Public Hospital from 19 February to 20 March, although he noted that there was a delay in the sending of this letter (it is dated 7 May).

Dr L stated that, notwithstanding the above, the lack of information provided to the Rest Home about Mrs A, although a contributory factor, was not the fundamental reason for the difficulties the Rest Home had in caring for her. She appeared to become ill, rather than progressively disabled, and required medical treatment from her general practitioner or the psychiatric nurse for the elderly.

Dr L further advised that my expert advisor had assumed that the service co-ordinator would provide ongoing clinical advice and assessment for Mrs A. However, in view of the numbers of frail elderly people in its area, the Service could not provide ongoing clinical advice and assessment for those in institutional care He expected registered nurses employed by these institutions to carefully monitor the condition of residents, identify deterioration and seek further information where required. Dr L noted that, notwithstanding the limited role of the service co-ordinator in Mrs A's care, she visited her on 19 April and arranged for her to be admitted to the Public Hospital on 23 April. She was also aware that Mrs A's general practitioner was visiting to assess her on 20 April.

Dr L acknowledged that there was a conflict of evidence about whether the service co-ordinator telephoned and advised the Rest Home to contact the duty district nurse from the Psychiatric Service for the Elderly if Mrs A deteriorated during the weekend of 21 and 22 April. He noted that the service co-ordinator had documented that the phone call occurred.

Dr D
In his response Dr D advised that he had been Mrs A's general practitioner for nearly 30 years. At the end of 2000 he transferred her care to another general practitioner closer to where she lived. From time to time Mrs A's family, specialists or a rest home would contact him and he would try to refer them to her new general practitioner. When he was notified that Mrs A was in the Rest Home, he went to see her during his lunch break on 20 April. He was struck by her deterioration as she looked frail and her speech was weak. However, Mrs A made sense, her pulse was regular, she had no fever and her blood pressure was normal and she did not appear to require acute admission to any general hospital.

Dr D advised that a nurse at the Rest Home informed him that Mrs A was being admitted to the Public Hospital as she did not meet the Rest Home's criteria and did not like being ordered about. He did not consider that Mrs A was at risk from rapid deterioration but he contacted the Public Hospital and was led to believe that she was being admitted on 20 April and therefore he did not arrange any further investigations or discuss an alternative plan. If he had known that the admission to the Public Hospital was to take place in a few days, he might have acted in a different way.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

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

…

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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Opinion: No breach – Mrs C and The Rest Home

In my opinion the Rest Home and Mrs C did not breach Right 4(1) and Right 4(5) of the Code of Health and Disability Consumers' Rights for the reasons set out below.

As stated by my advisor, this case highlights a lack of communication between the Public Hospital staff and the Rest Home staff, which significantly impacted on the care Mrs A received while a resident at the Rest Home. Mrs A was a complex resident who required a high level of care. The Rest Home was not fully informed of Mrs A's condition prior to her transfer on 9 April 2001, and was not offered the professional support necessary in the circumstances. As noted by my advisor, to place Mrs A in a rest home for respite care may have been appropriate, but not to provide the support and information that the facility needed to manage her was setting it up to fail.

Mrs C and the Rest Home were placed in a very difficult situation by the lack of adequate information on Mrs A's admission. Although there are aspects of the care Mrs A received while at the Rest Home that could be improved, the failure of the Public Hospital to provide sufficient information and support played a significant role in the events following her admission at the Rest Home.

I am reassured by the Board's response to my provisional opinion that it is working towards a broader assessment of the needs of frail older people which should ensure that carers are routinely provided with sufficient information. Nonetheless, I remain of the opinion that the Rest Home should have been provided with adequate information to care for Mrs A, particularly in view of her complex needs and the possibility of deterioration (which had happened previously in February 2001 in another rest home while Mrs A was having respite care). I acknowledge that the discharge letter was not available until 7 May, but the information could have been provided in another form.

I accept Dr L's comment in response to my provisional opinion that the lack of information the Board provided to the Rest Home about Mrs A, including information concerning her psychiatric condition, was not the sole primary or fundamental reason for the difficulties the Rest Home had in caring for her. There were other important contributory factors, for example the difficulty the Rest Home had in arranging a general practitioner to assess Mrs A (discussed below). Nonetheless, this does not detract from the significance of the information issue, particularly as Mrs A's condition deteriorated at the Rest Home.

I also accept that, in view of the numbers of frail elderly people in the region, the clinical role of the service co-ordinator was limited. Mrs A was in institutional care where registered nurses were available to assess and monitor her condition. However, in view of the temporary nature of the respite care and the fact that the Rest Home had insufficient information about Mrs A's complex needs and had not cared for her before, it is disappointing the service co-ordinator had little involvement with Mrs A's care until her visit to the Rest Home on 19 April 2001.

Assessment by doctor on admission

The policy in place at the time of Mrs A's admission required new residents to be assessed by a doctor within 24 hours of arrival. There was no equivalent policy in place about medical assessments for the admission of respite care only residents. The Rest Home did not routinely require respite care residents to be assessed by a doctor on admission if their medication was clearly documented and sufficient information about their condition was provided. My advisor noted that it would have been acceptable for the Rest Home to arrange a GP assessment only for respite care patients in these circumstances.

Mrs A's medication was not clearly documented on her arrival, and the Rest Home received little information from the Public Hospital on her admission. However, Mrs A was not assessed by a doctor on admission. In my opinion, in these circumstances, the Rest Home and Mrs C, as Nurse Manager, should have ensured that Mrs A was assessed by a doctor on admission, in line with the Rest Home's usual procedure.

There were, however, mitigating circumstances. Mrs A was clearly an exceptional case and Mrs C and the Rest Home were placed in a very difficult situation as there was significant confusion surrounding her admission. The Rest Home was provided with little information about Mrs A's condition on her admission, and was not informed who her GP was. Nevertheless, it appears that Mrs C and staff did take steps to establish Mrs A's current GP, telephoning the pharmacy that dispensed her medication to determine who was the most appropriate person to assess her (although it would have been wise also to have clarified her medication with the Public Hospital). Between 9 and 19 April, Mrs C communicated with Mrs B and the service co-ordinator in an attempt to arrange a suitable doctor to attend Mrs A. I am satisfied that Mrs C and the Rest Home acted reasonably in the circumstances, and did not breach the Code.

I note that to prevent this situation from recurring, the Rest Home now makes it clear that if a proposed resident's GP is not willing to see the resident within 24 hours of admission, then the House Doctor will be asked to admit the resident and document the medications.

Examinations following falls

Mrs A first fell at the Rest Home on the morning of 18 April 2001. Following this fall, nursing staff recorded a thorough assessment of Mrs A in her progress notes, checking her range of movement and that her weight bearing was satisfactory. No abnormalities were detected; however, it was noted that she was shaken and had slight bruising to the left cheek of her face. Follow-up comments were documented in the notes on 19 April, noting that she appeared satisfactory and, on 20 April, noting that bruising was still evident on her left cheek.

Mrs A had two further falls on 19 April. One Accident and Incident form was used to document both falls. The incident form notes that Mrs A was checked for injuries (none detected) and lifted to her feet.

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Mrs A had a further fall on 20 April. Again, an Accident and Incident form was completed, noting that Mrs A was checked for injuries (none detected) and assisted by two staff to her chair. The incident forms note that Mrs C, as Nurse Manager, was informed of all four falls.

Mrs B was concerned that a doctor was not called to assess her mother following the falls. The Rest Home Incident Policy requires a doctor to be contacted following a fall, if necessary. Nursing staff found no injuries. There is also evidence that Mrs A did not want to be assessed by a doctor. On 19 April, after Mrs A's third fall, Dr D was contacted and agreed to visit the following day.

According to my advisor, although the nursing staff appropriately checked Mrs A for injuries, they could have carried out a more thorough physical assessment of Mrs A following her falls; for example, by taking her blood pressure, noting whether she was febrile, and what could be causing her increasing confusion. I note that the Rest Home Incident Reporting Policy states that incidents are evaluated monthly to assess and identify risks areas and to identify action to minimise the risk of recurring falls. However, as noted by my advisor, this time frame is too long if a resident has an acute episode and a number of falls or incidents in a short space of time.

I accept that the nursing staff could have carried out a more thorough physical examination following Mrs A's falls. However, the evidence indicates that they did assess her injuries following the falls; were aware and concerned about her increasing number of falls, and deteriorating condition; and arranged for Dr D to assess Mrs A on 20 April.

Documentation of falls
The Rest Home Incident Reporting Policy requires staff to document the details of incidents clearly and accurately on an Accident and Incident form, and in the resident's progress notes.

Only Mrs A's first fall, on 18 April, was clearly and fully documented in her progress notes, including details of the bruising that she suffered. Accident and incident forms describing the fall, extent of injuries, and treatment given, were completed for all falls; however, the two falls on 19 April were recorded on one Accident and Incident form.

I accept my expert advice that although the documentation relating to Mrs A's falls was not consistent with best practice, in that the falls were briefly documented and more information concerning the physical examination undertaken should have been noted, the documentation was adequate.

Treatment when health deteriorated
My advisor noted that the first indication Mrs A was unwell was on 12 April, when an entry in her notes identifies that she complained of nausea. Mrs A's condition continued to deteriorate from this point. She became increasingly confused and delirious, was not eating, was refusing her medication, and was falling. The progress notes indicate that staff were aware of Mrs A's condition, identified her problems, and attempted to assess her condition.

As noted by my advisor, Mrs A's recordings were taken on 16 April, and staff attempted to get a urine specimen and to assist her with feeding. As Mrs A's condition continued to deteriorate, the notes indicate that Mrs C and staff became very concerned. On 18 April, Mrs C contacted Mrs B to inform her of her mother's condition. The service co-ordinator was contacted on 17 April, and asked to assess Mrs A. Dr D was called, and he visited on 20 April. Staff recognised the difficulties in caring for Mrs A, and hoped that the service co-ordinator or Dr D would facilitate Mrs A's referral to hospital.

My advisor noted that the delay in having Mrs A assessed by a doctor was not acceptable, particularly given that she had deteriorated so significantly since her needs assessment. However, Mrs C and staff were in a difficult situation. Mrs A was a complex resident who required a high level of care. Mrs C and staff were not aware of this at the time of her admission. They were provided with little information about her condition and care needs, and had difficulty locating a doctor to assess her, despite efforts to do so. Nevertheless, staff recognised that Mrs A's condition was deteriorating, and acted appropriately in the circumstances in calling the service co-ordinator and Dr D, two health professionals who knew Mrs A. Although there was a delay in contacting Dr D, account must be taken of the lack of information the Rest Home received on her admission and the confusion surrounding the identity of the best GP to assess her.

Weekend of 21 and 22 April

After her assessment of Mrs A on 19 April, the service co-ordinator arranged for Mrs A to be admitted to The Public Hospital on 23 April, when a bed was due to become available. Mrs C stated that she and staff were not happy with this plan, as they felt that Mrs A needed to be admitted before the weekend. Mrs C hoped that after Dr D assessed Mrs A on 20 April, he would transfer her to hospital. It appears that Dr D was concerned that the Rest Home was not the appropriate place for Mrs A, but he did not arrange for her to be admitted to hospital that day, and the plan remained for Mrs A to be transferred to hospital on 23 April. I accept Dr D's explanation that he genuinely thought Mrs A was to be admitted to the Public Hospital on 20 April and therefore he was not required to take any urgent action.

My advisor noted that given Mrs A's condition over the weekend of 21 and 22 April, Mrs C and the Rest Home should have sought medical intervention for Mrs A.

I accept this advice. With the benefit of hindsight, Mrs C and the Rest Home accept that Mrs A should have been admitted to hospital prior to or during the weekend of 21 and 22 April. Nevertheless, I also note that Mrs C and staff wanted to admit Mrs A to hospital; however, they felt constrained by the arrangement of the service co-ordinator for Mrs A to be admitted on Monday 23 April. The Rest Home was not accustomed to dealing with complex residents like Mrs A, and found it difficult to go against the wishes of Dr D and the Public Hospital staff. However, Mrs C has advised me that in the future she will not hesitate to do so.

Documentation and implementation of emergency care plan for the weekend of 21 and 22 April
The service co-ordinator recorded in her notes of 20 April 2001 that she informed Mrs C that if Mrs A's condition deteriorated over the weekend of 21 and 22 April, staff should contact the Psychiatric Service for the Elderly duty district nurse. This instruction was not recorded in Mrs A's progress notes, and Mrs C cannot recall being given these instructions. In the absence of any other evidence I am satisfied that the service co-ordinator's notes are a true and accurate record that the instruction in relation to any deterioration was given and therefore should have been documented.

However, I accept that, as Nurse Manager, Mrs C would have been aware of the need to take action if Mrs A's condition deteriorated over the weekend. Mrs C was in touch with nursing staff about Mrs A's condition over the weekend, and was informed that Mrs A's condition had not deteriorated.

Other Comments

Role of service co-ordinator
It appears that in this case the Rest Home was not clear about the extent of the role of the service co-ordinator during Mrs A's respite care. I view this with concern because it has the potential to disrupt the right of consumers to co-operation among providers to ensure quality and continuity of services (Right 4(5) of the Code). I urge the Board to reflect on this issue.

Respite care
The Rest Home has provided me with a specific admission policy for respite care. It has also provided me with a procedure for general admission which contains an addition for respite care concerning assessment by a doctor in the event the resident's general practitioner is unavailable. I draw the attention of the Rest Home to my expert's comment that respite care can be quite different to a full-time admission, and urge it to ensure that all other aspects of respite or short-term care are covered by appropriate policies.

Transfer to hospital
Section 30.1 of the Health and Disability Services Agreement for Rest Homes states that it is the responsibility of the Rest Home to ensure that ambulance services are available to acutely unwell residents. On the information provided, it appears that Mrs A was acutely unwell at the time of her transfer to the Public Hospital on 23 April. My advisor noted that, in her view, Mrs A should have been transported to hospital by ambulance on 23 April.

Mrs C advised me that she did discuss with Mr G the option of transporting Mrs A to hospital via an ambulance, and this discussion was noted in Mrs A's progress notes. Mr G

and Mrs B advised me that the option of having Mrs A transferred by ambulance was not discussed with Mr G.

I am faced with a conflict of evidence as to whether Mrs C offered to arrange for an ambulance to transfer Mrs A to hospital on 23 April. As health professionals responsible for the care of Mrs A, Mrs C and the Rest Home should have recognised that Mrs A was acutely unwell and required transportation by ambulance, and arranged it notwithstanding Mr G's offer to transport Mrs A himself, even if he had insisted. This is in line with Section 30.1 of the Health and Disability Services Agreement for Rest Homes.

Medication
My advisor noted that the documentation system at the Rest Home, although adequate, was certainly not best practice in relation to the administration of medications. My advisor identified that the Rest Home did not have an accurate record of when Mrs A refused her medications, and that she may have refused her medications more than seven times throughout her stay at the Rest Home. My advisor also noted that there is no designation on the Rest Home's drug-dispensing sheet to indicate what role staff had when administering medication.

Actions

- A copy of this report will be sent to the Ministry of Health Licensing Section and Residential Care New Zealand.

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