General Manager, Ms B

Clinical Co-ordinator, Ms C

A Rest Home

A Report by the

Deputy Health and Disability Commissioner

(Case 09HDC02110)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

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

Background

2. Mr A, aged 70, was a resident at a rest home. In mid-July 2009, Mr A became unwell with abdominal pain. Caregiver and Team Leader, Mr D, reported Mr A's condition to Clinical Co-ordinator and registered nurse, Ms C. Ms C instructed Mr D to telephone GP Dr E at his surgery to ask him to visit Mr A.

3. Mr D advised Dr E that Mr A had not had a bowel motion for three days. Dr E instructed Mr D to assess Mr A's vital signs of blood pressure and pulse and then report back. Mr D had difficulty assessing Mr A's blood pressure and pulse. He advised Ms C of his concerns.

4. Ms C assessed Mr A, reported his vital recordings to Dr E and made an appointment for him to be seen at Dr E's medical practice at 4.15pm. Ms C then left to attend a meeting at 2pm.

5. Mr A was escorted to Dr E's surgery at approximately 4pm. Dr E performed an urgent examination of Mr A's abdomen and diagnosed that he was seriously unwell. Mr A collapsed and died before an ambulance could be called. He was pronounced dead at 4.35pm.

Summary of findings

Ms C

6. Ms C was responsible for the overall management of patient care and was expected to provide care at the level of a registered nurse. Ms C failed to undertake an adequate assessment of Mr A's condition, and failed to give Mr D sufficient instructions for Mr A's care. Accordingly, Ms C breached Right 4(1)[1] of the Code. She also breached Right 4(2)[2] of the Code as her documentation did not meet professional standards.

Ms B

7. Ms B was the General Manager of the facility during the relevant time. Ms B was on duty on that day, but was not involved in Mr A's care that day nor was advised by any staff member that there were concerns about his condition. In the circumstances, it was reasonable for Ms B to assume that Ms C, the registered nurse responsible for the oversight of clinical care to residents, ensured that Mr A was provided with an appropriate standard of care. In my view, Ms B fulfilled her role as General Manager when she appropriately relied on Ms C to provide nursing care to residents. I find that Ms B fulfilled her responsibilities and did not breach the Code in relation to Mr A's care.

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

The rest home

8. The rest home had a responsibility to have structures in place to ensure that all its residents were provided with an appropriate standard of care. It is apparent that the Clinical Co-ordinator and the General Manager considered themselves to be overworked and not sufficiently supported to perform their duties adequately. Nevertheless, I find, upon review of all the relevant facts, that there is insufficient evidence to establish that the level of support Ms C had on the day that Mr A died was so deficient that she could not properly assess Mr A. Therefore, I find that the rest home did not breach the Code.

Investigation process

9. On 25 November 2009, the Health and Disability Commissioner (HDC) received a complaint from the Coroner about the services provided to Mr A by a rest home. On 20 January 2010, Mr A's wife, Mrs A, confirmed to HDC that she supported the complaint.

10. An investigation was commenced on 20 January 2010. The following issues were identified for investigation:

- *Whether the rest home provided Mr A with reasonable treatment and care between 30 September 2008 and the day he died in mid 2009.*
- *Whether registered nurse and General Manager, Ms B, provided Mr A with reasonable treatment and care between 30 September 2008 and the day he died in mid 2009.*
- *Whether registered nurse and Clinical Co-ordinator, Ms C, provided Mr A with reasonable treatment and care on the day he died.*

11. HDC identified the care provided to Mr A by Caregiver Team Leader Mr D on the day Mr A died as an issue for investigation, but was unable to notify Mr D of the investigation as he left the employ of the rest home after Mr A's death and his whereabouts are unknown.[3] Mr D did however, retrospectively record the incident in Mr A's "Progress Notes". That record is referred to in this Opinion where relevant.

12. The parties directly involved in the investigation were:

Mrs A	Complainant
Ms B	General Manager/provider
Ms C	Registered nurse/Clinical Co-ordinator/ provider
Rest home	Provider

[3] Health and Disability Commissioner Act 1994, s 41(1)(b).

Also mentioned in this report:

Mr D	Caregiver and Team Leader
Dr E	General practitioner
Mr F	Rest home director
Ms G	Mr A's friend
Ms H	Mr A's friend
Ms I	Current general manager

13. In assessing this complaint, HDC reviewed statements from Ms B, Ms C, Dr E, and one of the rest home's directors, Mr F. The information provided by the Coroner was also reviewed. This included Mr A's clinical records, statements from Ms H, Ms G, Dr E and Ms C's file note (dated the day following Mr A's death). Their statements are included in this Opinion where relevant.

14. Independent expert advice was obtained from registered nurse, Jenny Baker. Ms Baker has specialist knowledge in aged care. Her expert advice is attached as **Appendix A**. Ms Baker was requested to provide additional expert advice following the rest home's responses to the first provisional opinion. Her additional expert advice is attached as **Appendix B**.

Information gathered during investigation

The rest home

15. The rest home is a privately-owned aged-care facility. At the relevant time, the rest home offered Stage 2 rest home care and long-term medical care. The rest home company also owned a dementia unit on another site.[4] One of the Directors is Mr F.

16. During the relevant period, the General Manager of the rest home was Ms B. Her primary responsibility was to "Ensur[e] that the highest standard of nursing care is implemented according to current standards and Ministry of Health's contractual obligations".[5] At the beginning of 2009, Ms B was also responsible for preparing both facilities for Ministry of Health audits.

17. The Clinical Co-ordinator was registered nurse, Ms C. Ms C was responsible for "The assessment, planning, implementation, evaluation and monitoring of Client care".[6] Her duties included the "Supervision of all Registered, Enrolled and Caregiving staff while on duty" and the recording of Client Care plans.[7]

18. Ms B and Ms C were responsible for both the rest home and dementia unit facilities. Ms C worked at the rest home for three days per week and at the dementia unit for two days

[4] Mr F advised HDC that the dementia unit closed in 2010.
[5] An excerpt from the General Manager's job description (written on 24 July 2003) (amended on 22 November 2009).
[6] An excerpt from the Clinical Co-ordinator's job description (written on 9 October 2003) (amended on 29 May 2008).
[7] Ibid.

per week. She said that she and another registered nurse, who worked eight hours per week at the dementia unit, were responsible for "the Care Plans, Staff Appraisals, Care Review meetings, Education, Doctors Rounds and Orientation of new staff etc".

19. Mr D was employed as a Caregiver Team Leader.[8] As the rest home Team Leader, Mr D's role was to provide "Patient care under the direction and supervision of the Clinical Co-ordinator and/or senior nurses".[9] As a Caregiver, Mr D was required to provide day-to-day residential care and report patients' conditions to the registered nurses.[10]

Mr A

Background

20. Mr A was admitted to the rest home in September 2008.[11] Mr A suffered from chronic renal impairment secondary to hypertension, chronic constipation and schizoaffective disorder.

21. Mr A was reviewed monthly by GP, Dr E. Dr E described Mr A's health during his time at the rest home as "generally well … with most visits being for minor health issues."

22. In May 2009, Dr E noted that Mr A had diarrhoea with some blood, and in June recorded that Mr A was constipated. Dr E stated that Mr A was in "stable health" at his last consultation a few days before Mr A died.

23. Ms C advised HDC that it was known that Mr A had a chronic constipation problem and advised that there was a management plan for his condition. However, Mr A's Long Term Care Plan makes no reference to Mr A's chronic constipation problem and does not provide for any dietary or other plan to assist with his constipation.

24. The rest home advised HDC that it had a policy for "Care of Bowels" which required caregivers to record information about a patient's bowel motions in the "Bowel Book" after each shift, and report that information to the registered nurse or team leader. The registered nurse or the team leader had to check the "Bowel Book" upon commencement of their duty and, if appropriate, give the patient Lactulose syrup[12] or an enema.[13] If there was no result, then the doctor was to be contacted.[14]

25. HDC was not provided with the "Bowel Book" despite requests for all relevant documentation. However, Mr A's bowel movements were recorded in the "24 Hour Care Record" which documents the daily care provided to all patients including information about their bowel movement: "L=Large M=Medium S=Small B=Blood

[8] Mr D was a registered nurse in his home country. He did not hold a New Zealand nursing registration during his employment at the rest home.
[9] Excerpt from the Team Leader's job description (written on 9 October 2003) (amended 24 March 2003).
[10] Ibid.
[11] There is discrepancy in the documentation relating to the date of Mr A's admission. The date of admission is recorded as 19 November 2007 in the "Admissions Details" form. However, the remainder of the documentation relating to Mr A's admission records his admission date as 30 September 2008.
[12] Duphalac syrup contains lactulose which is used to treat constipation by increasing the water content and volume in stools to make the stools easier to pass.
[13] The introduction of a solution into the rectum for cleansing or therapeutic purposes.
[14] "Care of Bowel" (Written on 18 August 2003) (Amended 17 February 2009).

D=Diarrhoea H=Hard". For the three months leading up to Mr A's death there was either no information or an "N" recorded about Mr A's bowel movement. It is not clear whether "N" indicates normal or nil motion.

26. There is no record indicating that Mr A was suffering from any symptoms indicative of small bowel obstruction such as vomiting, cramping pain in the abdomen or bloating, prior to the day he died. However, Mr A's wife, Mrs A stated that when she visited Mr A four days earlier, he complained about a sore back and bad constipation. Mrs A stated that she and her daughter "noticed that [Mr A's] stomach was bloated" and reported this to staff.

27. However, the entry in the daily progress notes for the day of this visit only refers to a fall Mr A had that day and does not refer to any concerns Mr A's family expressed about his condition.

28. On the day of Mr A's death, Mr D was assigned the care of Mr A.

29. Mr D retrospectively recorded in Mr A's daily progress notes that he gave Mr A his usual medication in the morning and asked him whether he had a bowel motion. When Mr A answered no, Mr D gave him a dose of duphalac syrup.

30. Ms C's file note, dated the following day, records that at 8.30am she asked for a handover of all rest home residents, and Mr D reported that "everything was fine".

31. Ms C then went to her office to acquaint herself with the events that had occurred during her absence.[15] She noted the report of Mr A's fall four days previous and that his next of kin had not been informed. At approximately 11.30am, she went to the rest home wing to get Mrs A's contact details and, on her way there, she saw Mr A sitting outside smoking in the inner courtyard. She recalled that "[Mr A] did not look pale or unwell at this time".

32. Ms C stated that she asked Mr D about Mr A's fall and whether Mr A was complaining of any pain. Her file note records that Mr D reported that Mr A had not opened his bowels for three to four days and that the duphalac syrup that was given earlier in the morning had not worked. Ms C then instructed Mr D to give Mr A an enema while she phoned his family to inform them about his fall. In response to the first provisional opinion, Ms C said that Mr D did not tell her that Mr A had not had a bowel motion but just that he was constipated. This is inconsistent with the record made by Mr D and Ms C's own notes (see paragraph 47).

33. Ms C then went about her other duties for the day, which included making appointments for Mr A to see Dr E and a physiotherapist the following day.

34. Mr D recorded that he gave Mr A an enema and checked on him every 30 minutes.

35. Mr A's friends, Ms G and Ms H arrived at the rest home at 1pm to visit him. They went to his room and found him sitting on his bed. Ms H stated that she told Mr A that he "did

[15] Ms C was away for the previous four days.

not look good" and he replied that he had a lot of pain in his abdomen and had been constipated for a couple of days. Ms G and Ms H described Mr A as "agitated", "breathing heavily" and unable to keep still.

36. Ms G and Ms H asked Mr A if he had told the nursing staff that he was constipated. Ms G stated that Mr A replied that he had and was given "something to drink in the morning". Both recall that Mr A attempted to drink a can of soft drink but his hands were shaking so much that he spilt the drink all over himself.

37. Ms H said she went to the reception and told the receptionist that she was worried about Mr A. Ms H was told that the "man in blue" (Mr D) was taking care of Mr A and she should direct her concerns to him.

38. Ms H then went back to Mr A's room and found him lying on the bed, having difficulty breathing and talking about the "bad pain in his stomach".

39. Mr D arrived in the room and propped Mr A up with a pillow to help him breathe. Mr D asked Mr A where his pain was and whether the enema had worked. Mr A replied the enema had not worked.

40. Ms H and Ms G asked Mr D if Mr A could see a doctor. Mr D relayed that request to Ms C. Ms C instructed Mr D to give Dr E a call and explain the situation to him.

41. Mr D recorded:

> "I rang [Dr E] around 1330-1400 and told the status of [Mr A] and [asked] if [Dr E] can come see the client. [Dr E] said to check [Mr A's] vital signs and ring him back."

42. Dr E advised HDC that when Mr D called him around 1:30pm he got a "garbled message" about Mr A not having any bowel motion for three days, with no other information about his condition. Dr E stated that he instructed Mr D to take Mr A's vital signs and then call him back.

43. Mr D recorded that he attempted to assess Mr A's blood pressure and pulse but had difficulties taking his vital recordings:

> "I grab the BP Apparatus in my station and went to get the thermometer in the drug trolley but no thermometer. I went immediately to check the BP and pulse and can't listen to anything. I did it twice but still nothing and check also his pulse and it was weak and shallow."

44. Mr D recorded that Ms C arrived in Mr A's room, tried to measure his blood pressure and pulse but also had difficulties:

> "My superior arrived in [Mr A's] room and I told her I can't hear anything co'z it was weak and she also tried to get the BP and neither she can't hear anything even his pulse [sic]."

45. Mr D recorded that when Dr E rang back around 2.00-2.30pm, he informed him that he "can't hear [Mr A's] B/P [blood pressure] and it's below 100 and his pulse is weak". Mr D says he then gave the phone to Ms C. Dr E stated it was Mr D who called him back at approximately 1.45pm reporting that Mr A was afebrile, had a normal pulse but had difficulties measuring the blood pressure.

46. Ms C initially told HDC that she "did not assess Mr A [that day] as a sick patient as there were no reports made to me of this nature". She advised that she was busy with meetings all day, with a "compulsory meeting" at 2pm and then a 3pm meeting with Mr F.[16]

47. Ms C's initial response to HDC is inconsistent with her file note and the information she gave to HDC in an interview. The file note records that when she arrived at Mr A's room at sometime after 1pm she assessed him, informed Dr E of her observations and then made an appointment for him at Dr E's surgery at 4.15pm:

> "I got to [Mr A's] room … I introduced myself and explained the situation (Fall and constipation). … I asked [Mr A] if he had any pain, he said that he felt a bit uncomfortable in his abdomen. There was no sign of Shortness of Breath. When I asked about whether he had a sore back (from the fall), he said he had no pain at the moment. I asked [Mr D] if there was any results from the enema given, he replied 'no'. [Mr D] reported that he did not have anything to eat for lunch, had only drinks (ensure), he had had all his regular medication at 8.00am.
>
> I measured [Mr A's] Blood Pressure 98, which was below 100, Pulse 59 (weak and shallow). I informed [Dr E] by phone straight away."

48. At the interview with HDC, Ms C said that when she arrived at Mr A's room, Mr D had trouble assessing Mr A so she took over the assessment, measured the blood pressure at "98", and directly spoke to Dr E before leaving for her meeting at 2pm.[17]

49. In response to the first provisional opinion, Ms C said she did not consider Mr A was seriously ill at the time:

> "When I last saw [Mr A], after taking his recordings and prior to going to the meeting, I did not consider that he was seriously ill as he had been outside having a cigarette and walking around. I expect that observation had assured me about his health to some extent and that the appointment with the doctor was the appropriate course of action."

50. Ms C stated in response to the first provisional opinion that prior to leaving for her 2pm meeting, she gave Mr D instructions to check Mr A regularly and to come get her if there was any change in his condition. However Mr D did not contact her or any other registered nurse for assistance.

[16] Ms C told HDC that the 3pm meeting was to discuss her concerns regarding needing a full time RN at the dementia unit, and a pay rise. Mr F stated in his response to the first provisional opinion that the meeting was actually to discuss trust issues and did not in fact occur that day but was postponed. He provided an email to support his account.

[17] Dr E does not recall speaking with Ms C and he has no record of having the conversation.

51. Ms H and Ms G said that they advised Ms C that Mr A's family were overseas and that he needed to go to hospital or see a doctor immediately. Ms C replied that the doctor could not see him until 4.15pm. Ms H and Ms G both stated that they told her that Mr A needed to see another doctor or go to hospital and she replied that she could not do anything until she got Mr A's family's permission. Ms H and Ms G said that they left their contact phone numbers with a staff member and left at approximately 2.45pm.

52. Ms C disputes Ms H's and Ms G's account, claiming that she had left to attend a meeting at 2pm after she made Mr A an appointment with Dr E. By the time the meeting had ended, Mr A had already left.

53. Mr A was escorted to Dr E's surgery at 4pm. Dr E advised HDC that when Mr A arrived he was "clearly unwell with a grey complexion, slightly clammy skin, diaphoretic, not able to respond to questions, obvious abdominal distension, no apparent pain, weak pulse".

54. Dr E said that when he examined Mr A he noted his distended abdomen and quickly realised that he was seriously unwell and that his abdominal distension was increasing. Dr E took Mr A to the nurse's treatment room while an ambulance was called.

55. Mr A was only able to take a few steps before he collapsed. Dr E recalled that about two litres of bile stained fluid poured from Mr A's mouth. Dr E pronounced Mr A dead at 4.35pm.

56. The direct cause of Mr A's death was myocarditis and the antecedent cause, clozapine therapy. The other significant condition contributing to his death was noted to be hypertension and small bowel obstruction.[18]

General issues

57. As part of Ms B's and Ms C's responses to HDC's investigation, both stated that they were not provided with adequate support, had excessive workloads, and worked under difficult circumstances, which contributed to the events of the day of Mr A's death.

58. Ms B informed HDC that on that day, she and Ms C were "very busy" trying to catch up with everything that had happened in the weekend. She stated that she had arranged a "compulsory meeting" at 2pm to discuss the number of falls clients were having and therefore was not aware of Mr A's deteriorating condition at the time:

> "No one came in and interrupted to advise of the worsening condition of [Mr A], and I believe that [Mr D] never got the registered nurse in the Hospital to come and reassess [Mr A's] condition, as he worsened. [Ms C] and myself were not aware of [Mr A's] condition, or that he was becoming more unwell.
>
> [Mr A] was in the Resthome, which does not have 24 hours Registered Nurse cover, so it is the responsibility of the Team Leader to advise/access a Registered Nurse if they are concerned about a client. [Mr D] did not do this."

[18] Coronial Autopsy Report (4 September 2009).

59. Ms B and Ms C advised HDC that from February 2008 to early 2009 Ms B was on maternity leave, and during that time no staff orientation or education was provided. Mr F says that this claim is "totally untrue". He advised that there were three RNs working as educators in 2008, and resources were continually put into providing education. Furthermore, all new staff received orientation by a "buddy" system.

60. Ms B said complaints about the facility were being made to the Ministry of Health and when she returned from leave, she had less than three months to get the rest home and dementia unit facilities ready for a Ministry of Health audit and this was done in addition to her day-to-day duties. Mr F disputed that repeated complaints were made to the Ministry of Health about poor standards of care. Information provided by HealthCERT confirms that four complaints were made in 2008 and one of those (made on 26 August 2008) related to a lack of registered nurses. The other complaints related to insufficient heating, poor treatment of rashes, and heating and hygiene. All complaints were found to be unsubstantiated.

61. Ms B advised HDC that she raised concerns with Mr F about her workload and staffing levels, and she provided HDC with copies of correspondence and minutes of meetings with Mr F, dated from March to September 2009, indicating this. Mr F accepted that he received correspondence from Ms C about her employment conditions in June 2009 but said that her concerns related chiefly to material objects and money, not staffing levels. Further documentary evidence subsequently provided by the rest home, as part of its response to the first provisional opinion, shows a number of concerns were conveyed to Mr F by Ms B between 26 March and four days prior to Mr A's death, including concerns about workload, deteriorating standards, and staffing levels.

62. Ms C advised HDC that if one of the registered nurses called in sick, she and Ms B had to work overtime to cover for the nurse. Ms C said that they were not authorised to employ bureau nurses, and that care staff, domestic staff and registered nursing hours were being reduced between 2008 and 2009. Mr F refuted these claims and provided HDC with a summary of registered and bureau nursing hours in 2009, which he said demonstrated bureau nurses were used and staffing levels were sufficient. Ms I, current General Manager,[19] also provided information about RN hours. She stated that the rest home's records show that at that time there was a total of 1,233 RN hours which comprised 160 general manager hours, 160 clinical co-ordinator hours, 827 RN hours and 76 bureau staff hours. Ms I said that for a facility of 26 hospital beds, 20 dementia beds and 29 rest home beds, this "reflects a very good RN patient staff ratio".

63. In response to Ms C's and Ms B's claim of inadequate support and excessive workload, Mr F emphasised the following:

- there was a permanent RN at the dementia unit for three days per week (for only 11-13 patients);
- at all times, the rest home had 24-hour nursing cover;

[19] Ms I began her employment in November 2009.

- experienced RNs working as educators were available to provide senior clinical support;
- The dementia unit had a senior caregiver responsible for administration at the facility. This was not the responsibility of Ms C or Ms B;
- Ms B had another 100 hours of administrative support per week. These hours were used by staff who performed tasks such as payroll, accounts, reception, with additional time for assistance with audits and other tasks; and
- The rest home has always maintained the staffing ratios required by Ministry of Health regulations.

64. In response to the first provisional opinion, Mr F stated that the rest home had taken steps to advertise for RNs between April 2008 and October 2009 and, contrary to Ms B's evidence to HDC, had provided Ms B with assistance with recruitment.

65. Mr F advised HDC that throughout the relevant period the rest home always maintained the staffing ratios required by the Ministry of Health regulations and that the rest home met its obligations to provide education for staff members. He stated that:

> "Many of the allegations by [Ms B] and [Ms C] are false. Suggestions that the directors, in particular myself have not been aware of management issue at [the rest home and dementia unit] nor have responded to requests for assistance are incorrect. Senior staffing levels compare with other facilities of similar size. The ease with which [the current senior managers] are coping with the demands of their positions strongly suggests that it was the performance of [Ms B] and [Ms C] when they held these positions that caused any difficulties rather than the nature of the roles."

66. Ms B and Ms C are no longer employed at the rest home.[20] Both state that the primary reasons for their resignation were the excessive workload and the lack of employee support from Mr F.

Subsequent events

67. Mrs A advised HDC in her response to the first provisional opinion that she and her son later met with Ms B to discuss the circumstances of Mr A's final illness and death.

68. Mrs A claimed that Ms B said that she did not know what had happened and that she did not deal with this as it was the "hospital side's responsibility". Mrs A said that she expected that Ms B, as the General Manager, to have enquired into these events and have some information to give them.

Response to the first provisional opinion

69. The first provisional opinion was released on 17 December 2010. The rest home provided an extensive response to the opinion and further expert advice was sought (see

[20] Ms B resigned in October 2009 after ten years employment with the rest home. Ms C resigned in November 2009.

Appendix B). Mr A's wife, Mrs A, also provided a response to the first provisional opinion. Excerpts from the rest home's and Mrs A's responses have been added above where relevant. Ms B did not respond to the first provisional opinion.

Ms C

70. Ms C disputed my expert advisor, Ms Jenny Baker's, advice.

71. Ms C stated that although Mr D was employed as a Caregiver, he was a registered nurse in his home country and in 2009 he was applying for his New Zealand nursing registration. While Ms C acknowledged that this did not mean that Mr D is a registered nurse, she considered that he had a certain level of knowledge and skill that would generally be above that of a regular caregiver with no nursing training.

72. Ms C also stated that on the day Mr A died, she was working under difficult conditions due to having just returned to work after four days off and needed to catch up on what had happened during that time. Nevertheless, she also recognised that had she realised that Mr A was seriously unwell, she would have been able to make him her priority. Ms C also noted that she realised, on reflection, that she had relied on Mr D too heavily, which she attributed to her workload.

73. Ms C provided HDC with a letter of apology for the family which was forwarded to Mrs A on 24 February 2011.

Dr E

74. Dr E was asked to comment on the information gathered in the first provisional opinion.

75. Dr E stated that in his opinion the key issue in this case is the period between 2pm and the time that Mr A arrived at the medical centre critically unwell. Dr E said that he believes the management of Mr A prior to 2pm was "perfectly appropriate". Given the lack of concern by an experienced nurse together with the fact that Mr A was walking around smoking, Mr A's deterioration was very rapid.

Response to the second provisional opinion

The rest home

76. In the second provisional opinion, I recommended that the rest home presents this case in an anonymised form as an educative case study for its staff, review staff training in relation to the assessment and monitoring of residents, and obtain an independent review of its governance structures. Mr F and the rest home, in a joint submission, responded that there is no need for such recommendations as the rest home will be implementing the first two recommendations "on its own accord", and that past audits have shown a review of governance structures to be unnecessary. It was submitted:

> "[We] see merit in presenting a case study presentation to staff [as recommended by Deputy Commissioner Theo Baker]. That will be done on 11 January 2012 regardless of the finalised form of the opinion.

"[The rest home] is also in a continuous process of reviewing its staff training. There has already been an increased focus on assessment and monitoring of residents in the training offered. [The rest home] also has two of its current staff studying post graduate gerontology nursing and this should further strengthen the focus on assessment and monitoring of residents.

"[The rest home] does not see a need for a further independent review of its governance structures. Its governance is routinely reviewed as part of the independent audits that it undergoes. There has never been any criticism or adverse comment of the governance structures during these audits."

77. The rest home was concerned that my expert was critical of the clinical governance "when a key role in the clinical governance structure was the performance of [Ms B]". It was submitted that if there was to be an adverse finding about clinical governance (which would be unwarranted as a general finding) then that finding should be made against Ms B. To highlight the "deficiencies" in Ms B's performance, HDC was advised of a number of "beneficial changes" that the current manager was "able to implement by properly performing the same tasks that Ms B was responsible for". Those changes include:

- Ensuring that the daily handover reports involve the Clinical Co-ordinator and General Manager in addition to the Registered Nurses and other staff;
- Having a designated Registered Nurse employed for each of the three units (dementia, rest home, and hospital);
- Registered Nurses now promptly advise the Clinical Co-ordinator and General Manager of any issues that may suggest developing problems, or an alteration in a client's health status, and an action plan is developed by the Nurse, the Clinical Co-ordinator and the General Manager, with prompt follow-up to ensure that the situation is improving; and
- The Clinical Co-ordinator and General Manager alternate being on call to provide managerial input as required throughout the 24 hour period.

Ms B

78. Ms B provided a verbal response to the second provisional opinion. She advised that she is "concerned that it is her word against [Mr F's]" and that she "stands by her words".

Ms C

79. Ms C advised HDC that Mr F was not supportive of her when she told him that she could not continue to work the way she was. She said she was placed in a very stressful position.

80. Ms C provided a written evaluation of her documentation of resident assessment and care by her current clinical supervisor. The evaluation confirms that she is up-to-date

with the latest skills in aged care service provision, maintains resident care plans to an exceptional level, and performs her duties to that of a "Level 4 registered nurse".[21]

Opinion: No breach — Ms B

81. Ms B, a registered nurse, had been the General Manager since 1999. Her job description stated that she was responsible for ensuring that the service provided to the residents complied with current standards and the organisation's contractual obligations to the Ministry of Health. She was also responsible for ensuring that the "agreed" financial targets were met.

82. Staff training was not a specified responsibility in Ms B's job description, but she was responsible for the organisation's compliance with current standards and its contractual obligations.

83. While Ms B was on duty when Mr A's condition deteriorated, she was not involved in his care on that day and was not advised by the staff that there were any concerns about Mr A. It was only after Mr A died, that Ms B learned that he had been taken to see Dr E.

84. In the circumstances, it was reasonable for Ms B to assume that Ms C, the RN responsible for the oversight of clinical care, would undertake adequate assessments of residents, who were brought to her attention (such as Mr A) and take appropriate action.

85. In my view, Ms B fulfilled her role as General Manager and it was appropriate that she relied on Ms C to provide appropriate nursing care. Accordingly, Ms B provided a reasonable standard of care to Mr A and did not breach the Code.

Opinion: Breach — Ms C

86. In my view, there are three key issues in the assessment of whether Ms C provided Mr A with an appropriate standard of care. First, did Ms C conduct an appropriate assessment of Mr A? Second, did Ms C give Mr D adequate instructions prior to leaving for her 2pm meeting? Third, were Ms C's actions reasonable in light of the time constraints she claims she was under?

Adequacy of assessment

87. Ms Baker notes that the basic recordings and observations of low blood pressure, weak and shallow pulse, and abdominal pain clearly indicated that Mr A was very unwell and required immediate assessment. She states that Ms C did not adequately assess Mr A and, as a result, gave Dr E "woefully inadequate" information about Mr A's condition. Ms C did not examine Mr A's abdomen, did not ask about his bowel motions or whether

[21] A nurse who is adjudged by her employer to meet the "expert nurse" level on the Professional Development and Recognition Programme (PDRP) framework.

he felt sick. I agree that the assessment was inadequate and, therefore, appropriate information was not provided to Dr E.

88. In addition, regardless of whether Mr D had informed Ms C that Mr A had not had a bowel motion, or whether she believed that Mr A was not seriously unwell due to the observations she made earlier that day, the basic recordings Ms C took should have alerted her that Mr A was seriously unwell.

Adequacy of instructions given to Mr D

89. Ms C stated in her response to my first provisional opinion that before leaving for her 2pm meeting, she instructed Mr D to "regularly" review Mr A. However, Ms C did not give any instructions to Mr D as to how Mr A should be monitored and what steps to take if Mr A deteriorated. Her failure to do so meant that the instructions she gave to Mr D were inadequate.

Time constraints

90. Ms C stated that she was under time constraints and there were systemic problems that impacted on her performance.

91. I acknowledge that Ms C may have been operating under difficult circumstances at the time. However, in my view, Ms C had a duty of care to Mr A which should have taken take priority over attendance at a meeting.

92. Ms C had two options available to her. She could have stayed and fully assessed Mr A, including checking his abdomen and doing all basic observations, including temperature, pulse, blood pressure and respirations. Alternatively, Ms C could have asked the hospital wing registered nurse to do a full assessment and liaise with Dr E. As noted by Ms Baker, "at the very least", Ms C should have put in place a plan for Mr D to follow in the event that Mr A deteriorated.

Documentation

93. Ms C was responsible for the "assessment, planning, implementation, evaluation and monitoring of resident care" including ensuring that all care plans were legible and followed by the Team Leader, caregivers and registered nurses.

94. Ms C informed HDC that Mr A had a management plan for his chronic constipation problem. After reviewing all relevant clinical documentation, no evidence of a specific plan has been found. In addition, Mr A's Long Term Care plan does not outline dietary assistance for constipation and there is no written plan for the Team Leader or caregivers to follow to manage Mr A's chronic constipation.

95. Furthermore, Ms C only retrospectively recorded her assessments and did not record on the Multigraph TPR Chart or in the daily progress notes the recordings taken on the day Mr A died. This is in contravention of the *Health and Disability Services (General) Standards* and the Nursing Council of New Zealand's *Code of Conduct for Nurses and Midwives 2005*.[22]

[22] See Appendix C.

Conclusion

96. Ms C performed only a cursory examination of Mr A and failed either to arrange for another senior staff member to check on him or to provide Mr D with clinical instructions should Mr A deteriorate. This was unacceptable regardless of any time constraints Ms C felt she was under.

97. Ms C did not provide services to Mr A with reasonable care and skill and therefore breached Right 4(1) of the Code. She also breached Right 4(2) in that her standard of documentation fell short of the standards specified in the Nursing Council competencies.

Adverse Comment — The rest home

98. The rest home had a responsibility to have structures in place to ensure that all its residents were provided with an appropriate standard of care. It is apparent that the two staff members most responsible for ensuring that the policies were complied with and standards met (that is the Clinical Co-ordinator and the General Manager) considered themselves to be overworked and not sufficiently supported to perform their duties adequately.

99. Ms Baker advised that the "clinical governance and quality structures" in place at that time did not allow for adequate training, supervision and monitoring of staff. She was also of the view that Ms C's job description covered far too many responsibilities, affecting her ability to fulfil her role as Clinical Co-ordinator, and that Ms B was not provided with sufficient resources for her to function adequately in her role.

100. Although my expert considers that the "governance structures" were inadequate, the question of fact for me is whether there is a sufficient nexus between Ms C's act or omission and the alleged systemic deficiencies that existed at that time.[23] This involves a consideration of the level of support Ms C had, her responsibility as the RN and Clinical Co-ordinator and the circumstances of that particular day.[24] I find, upon review of all the relevant facts, that there is insufficient evidence to establish that the level of support Ms C had was so deficient that she could not properly assess Mr A.

101. I also note Ms Baker's comment that regardless of whether Ms C had a meeting that day, a resident's care should always take priority. Therefore, she should have stayed and fully assessed Mr A, asked another RN to do so, or given the caregiver sufficient instructions for his monitoring.

102. In my view, Ms C's failure to conduct a proper assessment is a fundamental clinical failure which cannot be attributed to any alleged systemic deficiencies. In any event, by employing an RN Clinical Co-ordinator to oversee clinical practice, the rest home took reasonably practicable steps to prevent its employees from undertaking inadequate

[23] Health and Disability Commissioner Act 1994, s 72(2) and 72(5).
[24] Health and Disability Commissioner Act 1994, s 72(5). See also Health and Disability Services Consumers' Code, clause 3.

assessments of residents. In the absence of any competency concerns, it was entitled to rely on Ms C to provide an appropriate standard of care to its residents at all times.

103. This Office has previously found rest homes not liable for the act or omission of its staff when the act or omission clearly relates to an individual clinical failure made by the staff member, including several cases where the staff member has cited workload and staffing issues for the failure.[25] Where there is a fundamental failing by an individual provider, a rest home will not be held liable for the individual's failings in the absence of conclusive evidence that the staffing levels and/or support were so deficient that it made the individual unable to perform their duties appropriately.

104. Accordingly, I do not consider that the rest home is liable for Ms C's failings.

105. I am, however, concerned about the level of support provided to the senior staff and the adequacy of the rest home's response to the concerns raised by Ms B between 26 March and a few days prior to Mr A's death.

106. I note that the rest home considers that any adverse finding about its clinical governance should be made against Ms B. I am satisfied that Ms B fulfilled her role by raising relevant concerns with Mr F. Those issues then became the rest home's responsibility to address.

107. I also note that when the dementia unit closed, all residents were moved to a new purpose-built facility on the rest home site. The dementia unit and the rest home are now connected with the hospital so that an RN is available to residents at all times. An additional RN was appointed to work full time in the rest home area, freeing up time to allow the current Clinical Co-ordinator to spend more time on teaching and audits.

Additional comment — Mr D

108. Mr D was employed as a Caregiver. It is irrelevant that he was a registered nurse in his home country, as that is not the basis on which he was employed.

109. Mr D was required to provide care at the level that would be expected of a competent caregiver, and in accordance with his job description. From the assessments he undertook, and the information he passed to Ms C, it appears that he did what was expected of him in the circumstances.

[25] Opinion 08HDC00469 and Opinion 02HDC17106.

Follow-up actions

- A copy of this report will be sent to the Coroner and the Nursing Council of New Zealand.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board and it will be advised of Ms C's name.

- A copy of this report with details identifying the parties removed, except the name of the expert who advised on this case, will be sent to HealthCare Providers New Zealand, HealthCERT (Ministry of Health), and the Association of Residential Care Homes and a copy will placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent expert aged care advice

The following expert advice was obtained by RN Jenny Baker:

"**Report on [the rest home]**

I have been asked to provide independent expert advice about whether [the rest home] provided [Mr A] an appropriate standard of care. I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

Professional Profile

I registered as a Registered Nurse in 1978. From 1978 to 1981 I worked as a Staff Nurse in Oncology. From 1981 until 1995 I worked as a staff nurse in acute wards, initially in medical wards and then in continuing care (post children) and then across all acute wards at Wairau Hospital. In 1995, I was Clinical Nurse Co-ordinator in an Assessment, Treatment and Rehabilitation Ward (AT & R) before taking up the position of Unit Manager, AT & R Unit, The Princess Margaret Hospital. I then held the position of Nurse Manager of a 99 bed private hospital for Aged Care. This included a Dementia wing, and palliative and young disabled residents. From 2002 to 2004 I worked as a Nurse Consultant providing documentation development and implementation for the Health and Disability Standards Certification and the Ministry of Health Contract. I also provided general consulting advice and training for both staff and managers. This was primarily with Aged Care facilities nationwide. During that time I kept my clinical skills current by working as an Agency Nurse in both the Public and Private sectors. From 2003 to 2004 I was a Lead Auditor for a Designated Auditing Agency against the Health and Disability Standards Certification. From 2004 until 2005, I worked as a National Quality and Training Manager for a company who owned retirement villages with rest homes and hospitals nationwide. From 2006 to 2007, I worked as a Care Manager in a rest home and rest home dementia, from 2007 to 2008 I worked in a generalist medical ward for a DHB public hospital and from 2008 to 2009 I worked as a Practice Manager for a very large General Practice. Since May 2009 I have worked in an acute orthopaedic ward and trauma unit which involved caring for patients with dementia and/or delirium and am currently a Charge Nurse Manager of an acute orthopaedic ward. I have provided expert advice to the Health and Disability Commissioner in the Aged Care area since 2002.

Expert Advice Required: [The rest home]

[Ms B]

1. Did [Ms B], as the General Manager of [the rest home], provide adequate leadership and training systems to ensure that an appropriate standard of care was provided to [Mr A]?
2. Is there anything else [Ms B] should have done in the circumstances?

[Ms C]

1. Did [Ms C], as Clinical Co-ordinator, take adequate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mr A]?
2. Were there any systemic factors impacting on [Ms C's] ability to ensure appropriate care was provided to [Mr A]?
3. Was [Ms C's] assessment of [Mr A] on [the day he died] reasonable?
4. Was the information she provided to [Dr E] adequate?
5. Were her instructions to [Mr D] regarding [Mr A] adequate?
6. Is there anything else [Ms C] should have done in the circumstances?

[Mr D]

1. Did [Mr D] perform an adequate assessment of [Mr A] on [the day Mr A died]?
2. Did [Mr D] provide an appropriate standard of care to [Mr A] on [the day Mr A died]?
3. Was the information he provide to [Dr E] appropriate?
4. Did [Mr D] appropriately document the situation?
5. What else, if anything, should [Mr D] have done in the circumstances?

[The rest home]

1. Were there adequate clinical governance and quality structures in place at [the rest home] [at that time]?
2. Did [Ms C's] job description and responsibilities enable her to fulfil her role as Clinical Co-ordinator?
3. Was [Ms B] provided with adequate resources to enable her to function adequately in her role as General Manager?
4. Did the systems in place at [the rest home] [at that time] allow for adequate training, supervision and monitoring of staff?

Degree of Departure from the standard

If in answering any of the above questions, you believe that [the rest home], [Ms B], [Ms C] and [Mr D] did not provide an appropriate standard of care, please indicate the severity of its departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

Are there any aspects of the care provided by [the rest home], [Ms B], [Ms C] and [Mr D] that you consider warrant additional comment?

Supporting Information

- Letter of complaint from Coroner, dated 23 November 2009, marked with an "a". (Pages 1 to 41)
- Notes taken during an interview with GP [Dr E] on 22 February 2010, marked with a "B". (Pages 42 & 43)

- Response from [the rest home], dated 30 November 2009, marked with a "C". (Pages 44 to 46)
- Response from RN [Ms C], dated 11 February 2010, marked with a "D". (Pages 47 & 48)
- Notes taken during an interview with [Ms C] on 13 April 2010, marked with an "E". (Pages 49 to 51)
- Response from General Manager [Ms B], dated 2 February 2010, marked with an "F". (Pages 52 to 54)
- [The rest home] records for [Mr A], including staff records and relevant policies, marked with a "G". (Pages 55 to 336)
- Notes taken during an interview with [Ms B] on 7 April 2010, marked with an "H". (Pages 337 to 339)
- Response received from [the rest home] – details of caregiver/Team Leader [Mr D's] performance appraisals, marked with an "I". (Pages 340 to 363)

Background

[Mr A], 70 years, was admitted to [the rest home] in November 2007 by the mental health team, for long term care for multiple medical problems (which included Type II diabetes, renal failure and COPD) and schizo-affective disorder.

On the afternoon of [a day in mid-2009], [Mr A] became unwell with abdominal pain. At about 1pm, [Mr A's] family who were visiting asked the rest home staff if he could be seen by a doctor. The caregiver Team Leader, [Mr D], attempted to take [Mr A's] blood pressure but was unable to obtain a reading. The registered nurse Clinical Co-ordinator, [Ms C], who arrived in [Mr A's] room to speak to the family on another matter, found that [Mr A] had a systolic blood pressure of 90 and instructed [Mr D] to telephone the doctor and make an appointment for [Mr A]. [Mr D] spoke to the GP, [Dr E], and then handed the telephone to [Ms C], who also spoke briefly to [Dr E]. An appointment was made for [Mr A] for 4.30pm.

[Mr A] was driven to the surgery by an untrained member of staff. Although [Mr A] was able to walk unaided into the surgery, he collapsed within minutes of arriving. The doctor estimated that about 2 litres of bile stained fluid poured from [Mr A's] mouth. He was pronounced dead at 4.35pm.

[Ms B]

1. Did [Ms B], as the General Manager of [the rest home], provide adequate leadership and training systems to ensure that an appropriate standard of care was provided to [Mr A]?

[Ms B] did not provide adequate leadership and training systems to ensure that an appropriate standard of care was provided to [Mr A]. As evidenced below under [the rest home] Question 3, [Ms B] was not provided with adequate resources to ensure that she could provide adequate leadership and training systems.

2. Is there anything else [Ms B] should have done in the circumstances?

[Ms B] had already emailed [Mr F] requesting an urgent meeting: *'Dear [Mr F], Can we have an urgent meeting to discuss staffing levels ... me and [Ms C] can not do everything and supervise everyone – this is a real worry to us. ... [Ms C] needs to be a* [sic] *[the rest home] x5 days per week, and we need to have someone else at [the dementia unit] for days also. We can not go on like this, we are getting burnt out and it has become dangerous. We need your help to recruit staff – we cannot do this ourselves'.*[26]

[Ms B] could have followed up this email (after presumably not receiving a favourable response) by emailing [Mr F] again informing him that if he was not able to respond to their need by increasing resources then it would leave [Ms B] no choice but to inform both the MoH and her DHB Planning and Funding Contract Manager of the situation and consequent risk.

[Ms C]

1. Did [Ms C], as Clinical Co-ordinator, take adequate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mr A]?

In my opinion, [Ms C] did not take adequate steps to ensure that [Mr A] received an appropriate standard of nursing assessment and care, as evidenced below in Question 3. [Ms C] appeared to be under a time constraint with the meetings she was due to attend. In my opinion, [Ms C] should have either taken the time to fully assess [Mr A] herself, or requested the hospital RN to come and further assess [Mr A] and liaise with [Dr E] or make the decision to order an ambulance to take [Mr A] to the public hospital for further assessment and treatment. In my opinion, [Ms C's] peers would view this conduct with moderate disapproval.

2. Were there any systemic factors impacting on [Ms C's] ability to ensure appropriate care was provided to [Mr A]?

Yes, in my opinion there were systemic factors impacting on [Ms C's] ability to ensure appropriate care was provided to [Mr A] as evidenced below under [the rest home] Question 3.

3. Was [Ms C's] assessment of [Mr A] on [the day he died] reasonable?

[Ms C] took the blood pressure which was low at 98/50-60 and the pulse as 59, weak and shallow. She had been informed that [Mr A's] bowels had not moved for 3-4 days; he had not moved his bowels following the lactulose syrup (oil) he was given that morning. She ordered [Mr D] to give [Mr A] an enema which did not produce a result. [Ms C] was informed by [Mr D] that he could not obtain [Mr A's] blood pressure.

[Ms C] stated in her statement to the Coroner dated [the day following Mr A's death]: *'I asked [Mr A] if he had any pain, he said that he felt a bit uncomfortable in his abdomen. There was no sign of Shortness of Breath ... I measured [Mr A's] Blood Pressure 98, which was below 100, Pulse 59 (weak and shallow). I informed [Dr E] by phone straight away ... I made a 4.15pm appointment at [Dr E's] surgery'.* She stated in her

[26] This quote relates to correspondence sent by Ms B to Mr F on 21 September 2009, after the relevant events.

response to the Senior Investigator for the Health and Disability Commissioner dated Received 16 Feb 2010: '*[Mr D] did not express to me, that he had any concerns regarding [Mr A], except the constipation. [Mr A] had a Chronic constipation problem, which we had a management plan for. I did not assess [Mr A] on [that day], as a sick patient, as there were no reports made to me of this nature'*. The staff interview with [Ms C] stated: *'[Ms C] recollection is that she told [Mr D] the BP was low (98/50-60) and for him to give [Dr E] the obs … She did take the phone off [Mr D] and spoke to [Dr E]. Arranged transport and went to her meeting'*.

[Ms C] did not examine [Mr A's] abdomen, ask whether he felt sick, what his bowel motions were like when they last went or whether [Mr A] was passing urine (a potential reason for abdominal pain from urinary retention when the bowel is full). I note that [Mr A] had dementia therefore had Short Term Memory Loss (STML); however depending on the level of STML, [Mr A] may have been able to give some indication. There is no record on the Multigraph T.P.R. chart or in the progress notes of any of the recordings taken on [that day]. I also note that it can be difficult for a Registered Nurse to assess a patient, particularly with a mental health problem, for what appeared to be a bowel obstruction; however the fact that [Mr D] was unable to hear the blood pressure and noted [Mr A's] pulse was weak and shallow and that [Ms C] herself noted [Mr A's] blood pressure was 98 and pulse 59 weak and shallow indicated that [Mr A] was clearly very unwell and required immediate assessment as to what the issue was.

I also note that [Ms C] stated as above that '*[Mr A] had a Chronic constipation problem, which we had a management plan for'*; there is no evidence of a specific plan to manage [Mr A's] chronic constipation within the documentation sent to me to review. The Long Term Care Plan for Eliminating does not have any documentation under Suppositories/Enema, Aperients/bulking agents. Under Client Goals it states: *'To remain continent and Independent as long as possible'*. The Long Term Care Plan for Eating & Drinking does not outline dietary assistance for constipation such as Kiwi Fruit Juice, increased fibre in meals and fresh fruit. There is nothing written on either care plan about [Mr A's] chronic constipation for the Team Leader to follow. The Policy: Care of Bowels outlines the procedure to follow if the client has not had a bowel motion for two days: *'On morning of second day – give 20 mls of Lactulose & encourage extra fluids. On morning of third day – give microlax enema. If no result inform Doctor'*. The policy does not link fibre in the diet with management of bowels or with the Policy: Dietary Needs of Clients.

In my opinion, [Ms C] did not adequately assess [Mr A], she relied on reports being made to her that a client was sick. In my opinion, [Ms C] should have been aware that [Mr A] was unwell, based on the observations of low blood pressure, weak and shallow pulse and abdominal pain, even if she was not sure what the problem was. She should have put in place more assessment, monitoring and an action plan for [Mr A] should he continue to deteriorate. She did not adhere to the Nursing Council of New Zealand's Competencies for registered nurses: *'Competency 1.3: Demonstrates accountability for directing, monitoring and evaluating nurse care that is provided by nurse assistants, enrolled nurses and others. Competency 2.2: Undertakes a comprehensive and accurate nursing assessment of clients in a variety of settings'*. In my opinion, [Ms C's] peers would view this conduct with moderate disapproval.

4. Was the information she provided to [Dr E] adequate?

In my opinion, the information, based on her inadequate assessment as evidenced above in Question 3, [Ms C] provided to [Dr E] was woefully inadequate; this would be viewed by her peers with moderate disapproval.

5. Were her instructions to [Mr D] regarding [Mr A] adequate?

[Ms C] stated in her statement to the Coroner dated 14.07.09: *'At approximately 1.00pm, [Mr D] came and said [Mr A's] family are here and they would like the Doctor to see him today. I told [Mr D] that that would be fine, give [Dr E] a call and explain the situation to him'.*

[Ms C] stated in the HDC interview: *'[Mr A] had looked OK in the morning. No SOB. No pain only a bit of discomfort in stomach. Family did not say why they wanted him to see Doctor. [Ms C] adopts an attitude that if a family requests it, then she goes ahead and does it generally'*

[Ms C] went to see [Mr A's] family to inform them of his fall. In the HDC Interview [Ms C]: *'[Mr D] had trouble getting BP obs. He could not hear it. [Ms C] took over. BP was 98 systolic. [Mr D] on phone to [Dr E] – [Ms C] took phone off [Mr D] and asked [Dr E] to see [Mr A]'.* In her statement to the Coroner [Ms C] states: '*I measured [Mr A's] Blood Pressure 98, which was below 100, Pulse 59 (weak and shallow). I informed [Dr E] by phone straight away'.* She arranged an appointment for [Mr A] at 4.15pm at [Dr E's] surgery; she informed [Mr D].

[Ms C] does not describe giving any other instructions to [Mr D]. [Mr A] had abdominal discomfort, had not moved his bowels for 3-4 days, had no response to the enema, had a low blood pressure along with a weak and shallow pulse; this collection of observations is significant and indicates that [Mr A] was not well; yet [Ms C] did not give [Mr D] any instructions as to how she wanted him monitored and if there was any deterioration what [Mr D] should do.

In my opinion, [Ms C's] instructions to [Mr D] were not adequate when she left the client to attend her meeting, in fact absent, and her peers would view this conduct with moderate disapproval.

6. Is there anything else [Ms C] should have done in the circumstances?

[Ms C] was due in a meeting at 2pm with the PM staff in the Hospital and was clearly under time pressure. [Ms C] had two possible choices, she could have stayed and fully assessed [Mr A] including his abdomen and all basic observations of temperature, pulse, blood pressure and respirations or she could have instructed [Mr D] to request the AM Hospital Registered Nurse to come and fully assess [Mr A] and follow up with [Dr E] accordingly. At the very least, she should have set up an assessment, monitoring and action plan for [Mr D] to follow if [Mr A] continued to deteriorate. [Ms C's] peers would view this with moderate disapproval.

[Mr D]

1. Did [Mr D] perform an adequate assessment of [Mr A] on [the day Mr A died]?

[Mr D] documented his notation of the events which occurred on [that day] after an RN had documented notification of [Mr A's] death at 1630 in the progress notes. [Mr D's] account documents asking [Mr A] if he had a bowel motion, administering him duphalac syrup with no result, informing his superior ([Ms C]) about [Mr A] not having a bowel motion for a few days, was given an instruction to administer an enema which he did. This is collaborated by [Ms C's] file note dated [the day following Mr A's death]: *'I went to the Rest home at approximately 11.30am...I asked [Mr D] how [Mr A] was ... [Mr D] told me that [Mr A] had not opened his bowels for 3-4 days and he had given him Lactulose Syrup earlier this morning, but he had had no result, I told [Mr D] to give him an enema'*. [Mr D] documents he gave [Mr A] his ensure drink, two relatives were present, the relatives noticed [Mr A] was unwell, asked for him to see a doctor, told his superior of the request, told to contact [Dr E], phoned [Dr E] around 1330-1400, told *'status of [Mr A]'*, asked for the doctor to come and see him, was told *'to check his vital signs and ring back'*. [Mr D] states: *'I went immediately to check the BP and pulse and can't listen to anything. I did it twice but still nothing, and check also his pulse and it was weak and shallow. My superior arrived in [Mr A's] room and I told her I can't hear anything coz it was weak and she also tried to get the BP and neither she can't hear anything even his pulse. [Dr E] I rang back around 1400-1430 and I told that I can't hear his B/P and it's below 100 and his pulse is weak and I gave the phone to my superior'*.

[The rest home] Job Description – Team Leader states: *'Responsible for: The provision of client care under the direction and supervision of the Clinical Co-ordinator and/or other senior registered staff ... Objectives: 1. To deliver appropriate and effective care and service as directed by the Clinical Co-ordinator and other Registered staff, to the clients of the facility ... 9. To have a clean, concise and accurate reporting method. 10. Accepts responsibility readily. 11. To supervise care giving staff'*

[Mr D] is a Team Leader, who effectively is a caregiver with responsibility for the other caregivers. He would be expected to be the liaison person between the caregivers/residents and the Clinical Co-ordinator/Registered Nurses and to follow any advice/instruction given by the Clinical Co-ordinator /Registered Nurses. He maybe expected to take basic observations of temperature, pulse, blood pressure and respirations by the Clinical Co-ordinator if there were concerns that [Mr A] was unwell, before he phoned the Doctor. I would expect the Doctor would require this information to assist him in making a decision as to when he should see [Mr A]. [Mr D] should not be expected to make an assessment of a resident at the level expected of Registered Nurses; indeed his job description as quoted above does not expect this of him. I note that the Job Description does not state that taking basic observations as outlined above is required from the Team Leader, so unless instructed by the Clinical Co-ordinator, [Mr D] would not think to take the basic observations prior to phoning [Dr E].

[Mr D] had informed the Clinical Co-ordinator that he could not hear the blood pressure and that [Mr A's] pulse was weak and shallow; he effectively passed on his concerns to

the Clinical Co-ordinator who had the responsibility of assessing [Mr A]. He should not be expected to examine [Mr A's] abdomen as this was well above his capabilities as a caregiver. In my opinion, [Mr D] carried out his duties as per his job description, assessed [Mr A] at his level and appropriately passed on the assessment information he was able to perform.

2. Did [Mr D] provide an appropriate standard of care to [Mr A] on [the day he died]?

[Mr D] documented comprehensively in [Mr A's] progress note outlining the care he provided to [Mr A] on [the day Mr A died]. [Mr D] states: *'I went for my break 1445 – 1500 and went straight to [Mr A] and ask if did bowel motion and he said no. I checked the client every 10-15 mins'*. [Mr D] does not write if he asked [Mr A] how he was feeling generally, was he in any discomfort or notate how he observed [Mr A's] physical condition; however he did not appear to have been given specific instructions to do so from either the Clinical Co-ordinator or the Doctor.

In my opinion, [Mr D] provided an adequate standard of care to [Mr A] on [that day]; he appropriately advised both his superior, [Ms C] and [Dr E] and followed their instructions; I would not expect a caregiver/team leader to have the nursing knowledge to assess [Mr A's] physical health concerns of a bowel obstruction.

3. Was the information he provided to [Dr E] appropriate?

[Mr D] contacted [Dr E] and asked him to come and see [Mr A]. [Dr E] states in his letter to the Coroner dated 05 Nov 2009: *'I was contacted by his caregiver (not nurse as recorded) around 1330 saying that [Mr A] was off colour, had not moved his bowels, and that his family who were visiting had requested that he be seen by a Doctor. … I advised that further triage was required and that he should check his basic recordings (pulse, blood pressure, temperature) and then report back. … He did call me back at approximately 1345 reporting that [Mr A] was afebrile and had a normal pulse. Blood pressure he had found difficult to assess and was not quite sure of his recording'*.

As above in Question 1 [Mr D] outlined the difficulties hearing the blood pressure and reported informing [Dr E] he could not hear the blood pressure but it was below 100, pulse weak and shallow. [Mr D] describes not being able to find the thermometer and does not document that he took [Mr A's] temperature; however [Dr E] states he was informed [Mr A] was afebrile (this means his temperature would have been in the normal range).

In my opinion, the information he provided to [Dr E] was appropriate. I would expect [Mr D], as a Team Leader, to take basic observations; however I would not expect [Mr D] to have the nursing knowledge in how to assess [Mr A] and know what other information should be given to [Dr E]. I would have expected [Ms C] to have assessed [Mr A] herself or arranged for one of the hospital RN's to assess [Mr A] and to instruct [Mr D] on what information to provide [Dr E] or preferably to have contacted [Dr E] herself.

4. Did [Mr D] appropriately document the situation?

[Mr D] has written a full account of what he did and what occurred to [Mr A] during his shift; however, I question the validity of his record of observations/questions about his bowel motions being *'every 30 mins'* and *'I checked the client every 10-15 mins';* this is not realistic and I believe would not have occurred within the documented timeframes. In my opinion, [Mr D] was documenting after the event recording everything he believed occurred; this documentation would be more appropriated as a file note, not normal documentation within client's notes. In my opinion, normal documentation is not usually this extensive and detailed with such tight timeframes.

5. What else, if anything, should [Mr D] have done in the circumstances?

[Mr D's] job description requires him '*to deliver appropriate and effective care and service as directed by the Clinical Co-ordinator and other Registered staff, to the clients of the facility'*; it does not require him to liaise directly with [Dr E] without being directed by the Clinical Co-ordinator and other Registered staff. [Mr D] informed [Ms C] and followed her instructions; this included phoning [Dr E] to inform him of the family wish for [Mr A] to be seen by a Doctor. [Mr D] was not left any instructions by [Ms C] when she left to attend the meeting at 1400.

In my opinion, [Mr D] could have requested a hospital RN, or the Clinical Co-ordinator, to come and assess [Mr A] again as the abdominal pain continued and he did not have a result from the enema. If [Mr D] was concerned about [Mr A] deteriorating, he could have phoned [Dr E] back to let him know. He could have taken the basic observations again to see if there was any deterioration however, I would not expect [Mr D] to have the knowledge to reassess the patient himself or necessarily know what else he could have done.

In my opinion it is important to note the following: The interview with [Ms B] by HDC on 7 April 2010 states: *'[Mr D] had Team Leader duties at a higher level to a caregiver's. [Ms B] said he was an RN in [his home country] but was not registered as an RN in NZ'.* Although [Mr D] was an RN in [his home country], he was not registered in New Zealand and therefore was not bound by the Nursing Council of New Zealand's Competencies for Registered Nurses. [Mr D] was appropriately employed as a Team Leader and adhered to his Job Description as outlined in Question one. The inference that as [Mr D] was an RN in [his home country] is completely irrelevant to his role as Team Leader. Indeed, this is supported by the current General Manager Ms I: *'I have read the Correspondence from the TL [Team Leader] on the [day of Mr A's death] and I believe he provided [Mr A] with all reasonable care within his scope of practice and reported his findings to his CC [Clinical Co-ordinator] on duty during the day as per procedure and policy and was also following the advice of the GP'.*

[The rest home]

1. Were there adequate clinical governance and quality structures in place at [the rest home] [at that time]?

No, the clinical governance and quality structures in place at [the rest home] [at that time] were not adequate as evidenced below in Question 3.

2. Did [Ms C's] job description and responsibilities enable her to fulfil her role as Clinical Co-ordinator?

[Ms C's] job description outlines her responsibilities with Personnel and Clients, in addition to administration, infection control, restraint, health and safety and general responsibilities. The amount of responsibilities outside of the straight clinical focus, which goes hand in hand with Personnel responsibilities, would have affected [Ms C's] ability to manage the staff and clients adequately. As the Rest Home had a Team Leader in charge rather than a RN, [Ms C] would have been required to complete and update all the Rest Home client's care plans and assessments; although I note the job description does not outline this role.

In my opinion, [Ms C's] job description covers far too much responsibilities and duties and would greatly affect her ability to fulfil her role as Clinical Co-ordinator; particularly as she covered two physical sites and 76 beds.

3. Was [Ms B] provided with adequate resources to enable her to function adequately in her role as General Manager?

[Ms B] stated in her letter dated 2 February 2010: '*The Registered Nurse hours were low, but I was not authorised to increase them … [Ms C] had a meeting with [Mr F] re: [Ms C] not having enough time to work between two sites … [Mr A] was in the Resthome which does not have 24 hours Registered Nurse cover … I returned, and had less than 3 months to get [the rest home]/[the] Dementia Unit, into some sort of order before the Ministry of Health did their surveillance audit'.* [Ms B] stated in her interview with HDC reps dated 7 April 2010: *'The year … while [Ms B] was away, was a mess. No education, training, or in-service was done. Filing system all over the place … all policies and procedure taken from folders and loose in a drawer. [Ms B] had only about 3 months to get [the rest home] back up to speed to comply with MOH audit specs … [Ms B] said there used to be a 12 hour "educator" role to help train caregivers'.*

[Ms C] stated in her letter dated 11 February 2010: *'I worked at [the rest home] only 3 days per week, and 2 days at the other site ([the] Dementia Unit … I was also working at [the] Dementia Unit for 16 hours each week, with only another Registered Nurse working for 8 hours per week only … Over the last 2 years [Mr F] has consistently been reducing the hours of the staff, including care staff, domestic staff and Registered Nurse staff. There were not enough Registered Nurse hours for both [the rest home] and [the dementia unit] sites (a drastic drop from 136 hours of Senior Management Staff to 64 hours at [the rest home], which meant that all the workload had to be done by myself and [Ms B] (General Manager) … [Mr F] had employed a Registered Nurse (Quality/Educator) in November 2008, for 40 hours per week, [Mr F] reduced her hours in March 2009 (approximately) to 24 hours, then to 16 hours, against our Managers wishes ([Ms B])'.*

[The rest home] had a total of 56 beds and with [the dementia unit's] 20 beds; this is a total of 76 beds over two physical sites. The Registered Nurse and Quality/Educator hours had been significantly reduced. [Ms C's] role as Clinical Co-ordinator was split over both sites. The 16 hours at [the dementia unit], along with the 8 hours of Registered Nurse was sufficient for 20 beds; however [Ms C's] remaining 24 hours of Clinical Co-

ordinator was not sufficient for 56 beds especially with her additional responsibilities with Infection Control and Restraint for the two sites.

[Ms B] had lost 24 hours of Quality and Educator hours which resulted in her taking on additional quality work to ensure the facility was ready for the MoH audit. [Ms B] was also responsible for both sites and would have had to divide her time between both sites; this would also have impacted on her ability to function adequately in her role as General Manager. There is an Education Calendar for 2009 which outlines a detailed list of education sessions for the year; however I am not clear on who took on the role of education and training.

In my opinion, [Ms B] was not provided with enough resources for her function adequately in her role as General Manager.

4. Did the systems in place at [the rest home] [at that time] allow for adequate training supervision and monitoring of staff?

No, the systems in place at [the rest home] [at that time] did not allow for adequate training, supervision and monitoring of staff as evidenced above in Question 3.

Jenny Baker, RN,
Expert Advisor"

Appendix B: Additional expert advice

Further expert advice was obtained from Ms Baker following the rest home's response to the first provisional opinion. In the interests of brevity, only part of Ms Baker's advice is provided below as her advice is succinctly and clearly summarised in the concluding paragraphs of her advice, as follows:

"Based on the above review of the new documentation provided outside my initial report I find no evidence to support changes to my initial opinions in relation to the excessive workloads that both [Ms B] and [Ms C] had during [Mr A's] tenure. [Mr F's] letter to the Health and Disability Commissioner dated 15/03/11 acknowledges the excessive workload from inadequate Educator and Quality hours by since increasing these hours. The excessive workload of the Clinical Co-ordinator is also acknowledged in [Mr F's] letter by since recruiting a full time Registered Nurse in the Rest Home and increasing the Registered Nurse hours to full time in the Dementia Unit, previously called […].

[Mr F] has produced evidence of governance in relation to "day to day" matters such as recruitment, equipment, repairs and maintenance, however, I have not been provided with any evidence of good clinical governance in relation to their clients and ongoing governance with the issues asserted by [Mr F] in relation to [Ms B] and [Ms C]. In fact [Mr F's] letter to HDC 15.03.11 reinforces my initial opinion regarding overall poor governance and particularly poor clinical governance.

Jennifer Baker RN
Expert Advisor"

Appendix C: Relevant standards

New Zealand Standard NZS 8134.0:2008

Health and Disability Services (General) Standard

"Standard 2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

…

2.3.9 Actual and potential risks are identifies, documented and where appropriate communicated to consumers, their family/whanau of choice, visitors, and those commonly associated with providing services. This shall include:

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented."

Nursing Council of New Zealand's Code of Conduct for Nurses and Midwives 2005

"Principle Two
The nurse or midwife acts ethically and maintains standards of practice.

Criteria
The nurse or midwife:

2.1 is guided by a recognised professional code of ethics applied to nursing or midwifery;

2.2 uses knowledge and skills for the benefit of patients/clients/community;

2.3 is accountable for practising safely within her/his scope of practice;

2.4 demonstrates expected competencies in the practice area in which currently engaged;

2.5 upholds established standards of professional nursing or midwifery practice."