Bupa Care Services

Registered Nurse, CM D

Registered Nurse, RN C

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC00783)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 8 September 2014, Mr A, aged 82 years at the time of these events, was admitted as a hospital-level care resident at the rest home following a prolonged period in hospital. Previously Mr A had had skin cancer removed and a skin graft performed, which required monitoring. Mr A required supervision for mobility, and full assistance with self cares. The DHB advised Bupa on admission to the rest home that Mr A's fluid intake would need to be monitored. At the time of events, the rest home was a newly developed rest home.

2. Mr A remained at the rest home between 8 September 2014 and 15 November 2014. Mr A's family visited frequently and, on 15 November 2014, took him to Hospital 1, as his health had declined. Mr A was found to be dehydrated, he had bilateral pneumonia, and he had lost weight.

Findings

3. Mr A was malnourished and required both assistance with, and oversight of, his consumption of food and fluids. Bupa failed to ensure that his nutritional needs were taken care of in a consistent manner, failed to commence a fluid balance chart, failed to monitor his weight, and failed to document progress notes on a consistent basis in line with policy. Bupa also failed to ensure that there were appropriate staffing levels, and that staff received an appropriate level of training and support to ensure that all of the above occurred appropriately.

4. Accordingly, it was found that Bupa failed to provide services with reasonable care and skill to Mr A, and breached Right 4(1) of the Code.

5. Adverse comment was made in relation to the care provided by Clinical Manager (CM) D to Mr A, and the level of oversight CM D provided in relation to his weighs, nutritional assessments, and the level of documentation. However, it was also accepted that the environment, staffing levels, and the training provided by Bupa to CM D, especially considering her lack of previous experience, contributed to the deficiencies in CM D's level of oversight of the care provided at the rest home.

Recommendations

6. It was recommended that Bupa provide a written letter of apology to Mr A's family for its breach of the Code. It was also recommended that Bupa conduct an audit of compliance with its Orientation Policy at the rest home for the preceding four months, conduct an audit of compliance with the nutrition and urinary tract infection policies for the past three months, and consider establishing a policy for the development and opening of new rest homes to ensure that appropriate staffing numbers and appropriate staff training occur.

Complaint and investigation

7. The Commissioner received a complaint from Mr and Mrs B about the services provided by Bupa Care Services NZ Limited (Bupa) to Mr A. The following issues were identified for investigation:

- *Whether Bupa Care Services NZ Limited provided Mr A with an appropriate standard of care between September 2014 and December 2014.*
- *Whether CM D provided Mr A with an appropriate standard of care between September 2014 and December 2014.*
- *Whether RN C provided Mr A with an appropriate standard of care between September 2014 and December 2014.*

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

9. The parties directly involved in the investigation were:

Mr and Mrs B	Complainants
Bupa Care Services NZ Limited	Rest home, provider
RN C	Registered nurse
CM D	Registered nurse and Clinical Manager

10. Information from the district health board (DHB) was also reviewed.

11. Independent advice was obtained from a registered nurse, Julia Russell (**Appendix A**).

Information gathered during investigation

Background

12. The rest home is owned and operated by Bupa Care Services NZ Limited and is contracted by the DHB to provide hospital, dementia, and palliative level care. At the time of events, the rest home was a newly developed rest home.

13. On 8 September 2014, Mr A, aged 82 years at the time of these events, was admitted as a hospital-level care resident following a prolonged period in hospital. Previously Mr A had had skin cancer removed and a skin graft performed, which required monitoring. Mr A required supervision for mobility, and full assistance with self cares. The DHB advised Bupa on admission to the rest home that Mr A's fluid intake would need to be monitored.

14. Mr A remained at the rest home between 8 September 2014 and 15 November 2014. Mr A's family visited frequently and, on 15 November 2014, took him to an after-

hours medical centre and he was transferred to Hospital 1, as his health had declined. Mr A was found to be dehydrated, he had bilateral pneumonia, and he had lost weight.

Clinical Manager (CM) — CM D

15. CM D's job description stated that her role included providing high level clinical leadership and support to clinical and care staff, monitoring the provision of clinical care to residents, and providing oversight of all resident clinical records to ensure that they met organisation and legislative requirements. CM D commenced employment at the rest home in 2014. She had not held a position within Bupa previously, had never held the role of a clinical nurse manager, and did not have hospital-level care experience.

Registered Nurse (RN) RN C

16. RN C's job description stated that her role included providing clinical care for residents as required. It also stated that her role included taking responsibility for the development of individual care plans based on comprehensive and documented assessments, and ensuring that individual care plans were updated and reviewed in a timely manner. RN C was assigned as the primary nurse for Mr A.

Nutrition and weight

17. On 8 September 2014, Mr A's discharge summary from Hospital 1 listed his weight as 53.15kg, and noted that recently he had lost a significant amount of weight. It is recorded that Mr A was underweight, anaemic and malnourished, and required regular fluids from a cup.

18. The DHB dietitian wrote to CM D and stated: "[D]iet prescription … is as follows: Puree texture … Regular feeding from cup … Requires feeding at times … 1 x Fortisip …" The dietitian also wrote: "Recommendations and strategies to improve patient safety are: **Diet:** Minced and moist diet (although Mr A preferred puree diet towards the end of his admission)."

19. The "Nutrition — Assessment and Management" policy in place at the rest home required a registered nurse to complete a nutritional assessment on all residents within a week of admission using the Mini Nutritional Assessment (MNA). The policy also stated that if a resident had a known history of unexplained or involuntary weight loss, or a physical condition on admission that suggested that the resident was nutritionally compromised, a nutritional assessment was to be completed within 48 hours of admission.

20. However, Bupa told HDC: "The admission checklist which was also in place in September 2014 stated that the MNA was to be completed within one week of admission, and we do acknowledge that this may have been misleading for the nurses involved in [Mr A's] care."

21. The "Nutrition — Assessment and Management" policy also required the nutritional requirements and dietary preferences for all residents to be identified at admission and recorded on the "Nutritional Requirements Form" and in the care plan.

22. Bupa told HDC: "[T]he Discharge information … indicated [Mr A] required both Minced-Moist and Smooth/pureed textures to be provided. As this was not clarified by our staff, directions written by the admitting nurse were also confusing." Bupa accepted that the information regarding Mr A's nutritional requirements was unclear, some of which were documented by Bupa staff. The admission documentation completed by Bupa stated that Mr A was underweight at 50.6kg, and required a special diet of soft foods.

23. On 15 September 2014 (a week following admission), RN C completed a nutritional assessment for Mr A using the MNA, and obtained a "Total Malnutrition Indicator Score" of 7.5 out of 30.

24. The "Nutrition — Assessment and Management" policy outlined that, if a resident had an MNA score of less than 17, the resident's GP was to be informed immediately and an urgent referral made to a dietitian. It also stated that staff would commence a nutritional record, make an entry in the short-term care plan, and that if nutritional intake could not be improved by diet alone, oral nutritional supplements may need to be given. It stated that the MNA was to be repeated monthly.

25. In this instance, no referral was made to a dietitian, Mr A's GP was not informed of his MNA score, and no nutritional record was commenced. Bupa told HDC that at this time a dietitian was not available to the rest home. RN C told HDC: "[A]t the time, after realising that a dietitian had recently seen Mr A and considering that the GP was aware of Mr A's condition, a second referral was not made at this time."

26. RN C documented that Mr A was to be weighed weekly. On 21 September 2014, RN C recorded Mr A's weight as 53.7kg. On 29 September 2014, RN C documented under the "Eating and Drinking" section of Mr A's care plan that staff were to provide three balanced meals daily, hot drinks, supper, a water jug in his room, and nutritional supplements, and that staff were to encourage Mr A with eating, ensure he was eating well, and weigh him weekly. She documented his weight as 55kg.

27. On 7 October 2014, RN C documented Mr A's weight as 56.5kg. No weights are recorded after this date. On 12 September 2014, RN C documented that Mr A refused to be weighed. RN C could not recall whether this was always the case. She told HDC: "I agree that it ought to have been done weekly, but do not accept that it was my sole responsibility and I do not understand why no one else did any weighs."

28. Mr A's son-in-law, Mr B, and Mr A's daughter, Mrs B, told HDC that Mr A seldom received food that was puréed, and that he was given "little or no assistance with meals". They told HDC: "[W]e witnessed meal simply being placed in front of [Mr A] and collected later without interaction as to why meal was barely eaten." They stated that on one occasion, a family member chased the meal trolley to request a meal for Mr A.

29. Bupa was unable to ascertain whether any such incident had occurred, but stated that, if such an incident did occur (Mr A not receiving a meal), it would have been an accident on behalf of the person who was delivering the meals.

30. As stated above, Mr A was prescribed the nutritional supplement Fortisip prior to admission. Although the medical chart includes some references to Fortisip being provided to Mr A, the chart does not reflect the prescription of one Fortisip daily. On 4 November 2014, the first reference to Fortisip was made in the progress notes. It is recorded that, as a result of a family meeting, the rest home staff were to ensure that Mr A received two Fortisip supplements daily.

31. CM D told HDC that the registered nurses were not signing the medication sheet when they provided Fortisip, and often the caregivers would give it out without telling the nurse on duty. CM D stated that she was trying to address this at the time, "as the perception by staff was that a food supplement was not a chartable treatment". RN C told HDC that when she was on duty, Mr A received the Fortisip and his meals.

Documentation

32. The Bupa policy "Progress Notes" required staff to record a client's progress and document changes in condition, including the care and treatment provided, the observation and assessment of symptoms, and changes in the resident's physical condition.

33. The policy also stated that, for hospital-level care residents, progress notes should be completed at a minimum of once every 24 hours where a resident's condition is stable, and as frequently as required if a resident becomes unwell, at least once per shift.

34. During Mr A's admission to the rest home, the registered nurses and caregivers involved in his care generally recorded his daily activities and health in the progress notes. However, on 21 shifts between 12 October 2014 and 27 October 2014 there are no progress notes, and there is no record of any hygiene cares having been provided.

35. CM D told HDC that she was on annual leave between 12 and 20 October 2014, and that no other clinical manager was engaged by Bupa to cover her absence.

36. Bupa told HDC that, although the staff failed to document anything in Mr A's progress notes during the shifts listed above, on other occasions, documentation was instead recorded in other places, including the Clinical Manager's diary. Bupa provided a copy of the diary, which shows multiple brief entries between 14 and 17 October 2014, between 21 and 23 October, and on 29 October 2014, which relate to Mr A's general activities and appointments.

37. In particular, I note that between 8 September 2014 and 15 November 2014, it is documented that three shower offers were declined by Mr A, and that 19 body washes were provided. There are eight additional references to "all cares done", and to six showers having been accepted by Mr A.

38. Bupa told HDC:

> "We acknowledge that the impact of opening the rest home … in July 2014 … and admitting a large number of residents over a short period of time, with a new

> team, may have impacted on the staff's ability to complete required documentation to the appropriate standard. Bupa has reflected significantly on this complaint … and made considerable changes to the process of commissioning new care homes."

Staffing levels and training

39. Mr and Mrs B told HDC that it was clear to the family that there were issues with staffing levels, and that the standard reply from Bupa staff was: "[W]e are a bit short staffed just now as we have just opened." Mr and Mrs B told HDC that they found it very difficult to find staff when they were visiting.

40. Bupa told HDC that the rest home had rostered two registered nurses for morning and afternoon shifts, and one for the night shift. Bupa stated:

> "We do believe that staffing levels were matched to the numbers of residents and their assessed level of care as per the organisations staffing structure. I believe that as the residents chose the rooms they wanted to stay in, this also meant that some were spread out across a part of the facility which staff may also have found challenging."

41. Bupa told HDC that originally Mr A and his family chose a room in a wing where Mr A was the only resident in that area at that time. Bupa said that there was decreased visibility from staff in this wing. Bupa stated:

> "Prior to opening the rest home all staff employed at that time completed a 4 day orientation which covered most of the care plan … Due to the rest home being a new service, the educational needs of the new staff is ongoing (as we increase staffing frequently)."

42. Bupa said that immediate steps were taken to address the concerns raised in the complaint by Mr A's family. Bupa stated: "This includes some additional training for the [Clinical Manager] (who was new to her role) and [mentoring] by a senior [Clinical Manager] from another facility."

43. In addition, Bupa identified that when the rest home first opened, it had poor attendance rates at training sessions, and, of particular note, no staff enrolled to attend the nutrition session that was organised. Bupa stated that following these events, training sessions were made compulsory.

44. Bupa provided HDC with the staff training records and orientation records for RN C and CM D. It is documented that CM D did not receive her initial training on "Nutrition and Hydration" until 12 August 2015. No completion date is recorded for RN C, and it is not recorded that RN C read the "Feeding a Resident" policy. In addition, there is no record of RN C having received training on nutrition.

45. CM D stated:

> "During the time frames missing in the [progress notes], we would have been admitting 4–6 residents a week, with ongoing recruiting and orientating of new staff as the numbers increased. I was working as a caregiver, RN and trying to learn a new [Clinical Manager] role, without the mentorship I was promised."

46. During her three-month appraisal (completed eight months after her commencement of employment) following completion of her orientation with Bupa, CM D documented her dissatisfaction with the level of training and mentorship she had received as Clinical Manager. Although this document allowed for comments and a signature from a Bupa "appraiser", the document was not completed by any individual other than CM D.

47. Bupa told HDC that, following receipt of this complaint, CM D was provided with a formal mentor. Bupa also said that there is now an agreement in place to recruit only experienced Bupa staff into key positions following the opening of a new facility, and that all clinical managers are to have "support buddies" from other clinical managers of care homes in the same region. Bupa also recognised the need to ensure that it dedicates resource to coordinate the commissioning of new care homes, and the importance of the appointment of a project manager.

Transport to appointments

48. Mr and Mrs B complained that Bupa provided no support to Mr A with transport to hospital appointments, and that the family had to manage transport.

49. The rest home confirmed that transportation to and from appointments was supposed to be provided by the rest home in accordance with the agreement between the rest home and the family. Bupa told HDC that, at this time, there was no mini-van, and that, once there was, there was no staff member adequately trained to drive it.

Urinary tract infections

50. During Mr A's stay at the rest home, he contracted multiple urinary tract infections. The urinary tract infection policy at Bupa at the time of these events required nursing staff to commence a fluid balance chart to measure intake and output, and to make regular entries in the progress notes regarding fluid intake and output.

51. While staff recorded instances where Mr A had consumed fluids throughout his admission, a fluid balance chart was not created for Mr A during his time at the rest home, nor was his input or output of fluids measured and recorded anywhere else in his documentation.

Deterioration in condition

52. On 16 October 2014, Mr A had a sore throat and subsequently was prescribed antibiotics. On 29 October 2014, a registered nurse documented that Mr A was not well, was confused, and was not drinking. A urine sample was sent to the laboratory for testing, and it was documented that the GP was to be called, and that if the GP was not available, Mr A was to be sent to the hospital the following day. On 30 October 2014, Mr A was reviewed by a doctor who prescribed treatment for thrush.

53. Between 4 November and 11 November 2014, staff at Bupa regularly documented whether Mr A was settled during the night, and, on one occasion, that he appeared confused. On 11 November 2014, CM D contacted the doctor.

Further information

54. CM D told HDC:

> "I would like to take this opportunity to apologise to the family for the concerns that they have about the adequacy of the care provided to [Mr A]. I have taken their complaint very seriously and have used it as an opportunity to directly improve my practice."

55. RN C told HDC:

> "I am very sorry for the distress and upset caused to [the family], and apologise if it is considered that the care I provided to [Mr A] did not meet the required standard."

Responses to provisional opinion

56. Mr and Mrs B were provided with a copy of the "information gathered" section of the provisional opinion. They told HDC:

> "We do appreciate that changes have been made for the better, and these will benefit other residents and create a greater awareness by staff, but we are very disappointed that [Mr A] and his family were so badly let down."

57. Bupa was provided with a copy of the provisional opinion. Bupa told HDC:

> "It is with deep regret that Bupa acknowledges and accepts the provisional findings in the Commission's report. Bupa also accepts the proposed recommendations … We will initiate the implementation of the recommendations, including the audits, in collaboration with the regional Operations Manager (OM) and Care Home Manager (CM)."

58. Bupa also told HDC:

> "We have contracted the services of an external project manager to help us design a standard system to ensure a safe and managed opening process for new care homes. This will include operational, property and clinical systems and processes that are both sustainable and reproducible. This work will begin in June 2018."

59. CM D was provided with a copy of the relevant sections of the provisional opinion. CM D told HDC:

> "I once again wish to reiterate my sincere apologies to [the family], that the clinical oversight of the care provided by me during the 11 weeks he was a resident at the rest home was not at the expected professional level."

60. RN C was provided with a copy of the relevant sections of the provisional opinion. RN C had no further information to add.

Opinion: breach — Bupa

61. Bupa had overall responsibility for ensuring that Mr A received an appropriate standard of care at the rest home. It needed to have in place adequate systems, policies, and procedures, and then ensure compliance with those policies and procedures so that the care provided to Mr A was appropriate and that any deviations from good care were identified and responded to. Bupa also has a responsibility for the actions of its staff.

62. Mr A was let down by various aspects of the care provided to him by numerous staff at the rest home during his stay. Expert advice was obtained from RN Julia Russell, and I am mindful of RN Russell's comments that the rest home was a recently opened facility, and her observations that, given this, it is difficult to establish who held responsibility for the failures identified in Mr A's care. I agree with RN Russell's comment that, at a newly opened rest home, issues such as documentation "seldom are the responsibility of just one person or group".

63. Bupa 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 Manager, who held the majority of responsibility for ensuring that the policies were complied with and standards met, considered herself to be overworked and not sufficiently supported to perform her duties adequately. In particular, I note Mr and Mrs B's and CM D's comments relating to the staffing levels and the workloads placed on staff at the time of Mr A's stay at the rest home.

Staff levels and training

64. RN Russell has advised that it is apparent that staffing levels did not keep up with resident numbers. She further advised: "[I]t seems that the ability to keep up with the care provision as well as the needs of new staff with new residents was compromised at times." I also note RN Russell's advice that although in New Zealand there are no mandated requirements for staffing levels, the "SNZ HB 8163:2005 Indicators for safe aged-care and dementia-care for consumers",[1] while outdated, is a useful measure for evaluating staffing levels, and she considered these in relation to her advice. I note that RN Russell also advised that, in her opinion, the staffing numbers at the rest home during the times of Mr A's stay demonstrate that the ratio of staffing numbers did not keep up with the resident numbers.

65. Bupa has acknowledged that the impact of opening the rest home in July 2014 and admitting a large number of residents over a short period of time may have impacted

[1] As stated in the title, the requirements in this document are indicators only and provide the sector with guidance on staffing levels.

on the ability of staff to complete required documentation to the appropriate standard. It is also apparent that the level of induction, training, and monitoring of CM D and RN C was insufficient in line with the requirements at Bupa. In addition, during CM D's three-month appraisal (completed eight months after her commencement of employment) following completion of her orientation with Bupa, CM D documented her dissatisfaction with the level of training and mentorship she had received as Clinical Manager. Although this document allowed for reviewer comments, the document was not completed by any staff member senior to CM D. Also, CM D had not held a clinical manager role previously, nor had she had any experience with hospital-level care.

66. Furthermore, Bupa identified that there was a history of poor attendance at training sessions that were organised (including a zero attendance rate at a training session on nutrition), and that such training sessions were made compulsory only following the complaint.

67. It is documented that CM D commenced her orientation in mid 2014 and completed it in late 2014. It is also documented that CM D did not receive her initial training on "Nutrition and Hydration" until after the rest home ceased providing care to Mr A.

68. In addition, I note that, although it was included in the agreement with Mr A, transportation to appointments was not provided as agreed, as no staff member was trained to drive the van.

Nutrition and weight

69. RN C did not perform a nutritional assessment for Mr A until 15 September 2014, being a week since Mr A was admitted on 8 September 2014. Bupa told HDC that although the policy stated that a nutritional assessment should occur within 48 hours in cases where the resident is nutritionally compromised, the checklist in place stated that a nutritional assessment was to be completed within a week. Bupa accepted that this may have caused confusion for the nurses. RN Russell advised that Mr A's condition met the criteria of being nutritionally compromised.

70. In addition, the "Nutritional — Assessment and Management" policy in place at the rest home required monthly nutritional assessments and review by a dietitian for a resident in Mr A's condition. No repeat nutritional assessments were performed, and no consultations with a dietitian were sought during the duration of his stay. I note that Bupa accepted that there was no dietitian available to the rest home at this time, and I also note that there is no instruction in the policy outlining what to do in this situation. Although RN C did record in Mr A's care plan that Mr A's weight was to be taken and recorded on a weekly basis, there were no weights recorded following the 7 October 2014 review.

71. RN Russell advised:

> "Whilst [the rest home] staff … were certainly aware of and recording [Mr A's] deterioration, the ongoing recording of his weight would have assisted them in considering what actions they could best take to support [Mr A] and his family. It

> does not meet the expected standard for the [registered nurse] who should have continued with recording the weights or the [Clinical Manager] who should have been monitoring [Mr A's] weight."

72. I accept that advice and consider that the monitoring of Mr A's weight, the failure to establish a nutritional record, and the failure to repeat any nutritional assessments — by multiple nurses, as required by the policy — was inadequate over Mr A's period of admission at the rest home. I am also inclined to accept Mr and Mrs B's recollection that, on at least one occasion, Bupa staff took away a meal that had been untouched by Mr A, without discussing this with him or providing him with encouragement to eat. In addition, the DHB informed Bupa that Mr A preferred puréed foods, and I am of the opinion that Bupa should have offered Mr A this consistency of food to encourage his nutritional intake.

Monitoring of fluids

73. The DHB told Bupa that Mr A's fluid intake would need to be monitored, and that Mr A had suffered numerous UTIs. During Mr A's admission to the rest home, staff did not instigate a fluid balance chart for Mr A, nor was his input or output of fluids measured. This was not in line with the Bupa policies in place at the time. The failure by staff to adhere to the fluid and urinary tract infection policies in place at Bupa was unacceptable. Bupa told HDC that it accepts that there are no records of formal monitoring of Mr A's food or fluid intake.

Documentation

74. During Mr A's admission to hospital-level care at the rest home, the registered nurses and caregivers involved in his care generally recorded his daily activities and health in the progress notes. However, there are no progress notes recorded on numerous shifts between 12 October 2014 and 27 October 2014.

75. I note that progress notes (12–20 October) note Mr A as being unwell and, in particular, as having a sore throat. In addition, subsequently Mr A was commenced on antibiotics. I am of the opinion that the frequency of progress notes was insufficient for a man in Mr A's condition. RN Russell advised: "Given [Mr A's] health issues and if all the notes were available the level of departure from the standard in this area would be considered minor." I am unable to make a finding as to the adequacy of the hygiene cares provided, owing to the absence of progress notes during a number of shifts.

76. As mentioned above, Bupa has acknowledged that the impact of opening the rest home in July 2014 and admitting a large number of residents over a short period of time may have impacted on the ability of staff to complete required documentation to the appropriate standard. Bupa told HDC that it "has reflected significantly on this complaint … and made considerable changes to the process of commissioning new care homes".

Hygiene

77. In relation to hygiene, RN Russell advised: "It appears the greatest deficit here is in ensuring that the family understood why [Mr A] did not want to shower and ensuring they were aware of that and were even involved in encouraging him." I agree that Bupa could have made a greater effort to encourage Mr A in relation to his hygiene cares.

Conclusion

78. I accept that, on admission, Mr A had recently had a prolonged hospital stay and had significant physical issues that required assistance. I also note that it was apparent that his condition might deteriorate; however, it is also apparent that the lack of appropriate management he received at the rest home contributed to his condition.

79. Bupa failed in its duty to ensure that Mr A received services of an appropriate standard while at the rest home. As set out above, Mr A was malnourished and required both assistance with, and oversight of, his consumption of food and fluids. Bupa failed to ensure that his nutritional needs were taken care of in a consistent manner, failed to commence a fluid balance chart, failed to monitor his weight, and failed to document progress notes on a consistent basis in line with policy. Bupa also failed to ensure that there were appropriate staffing levels and that staff received an appropriate level of training and support to ensure that all of the above occurred appropriately.

80. I therefore conclude that Bupa failed to provide services with reasonable care and skill to Mr A, and breached Right 4(1) of the Code.

Opinion: no breach — RN C

81. RN C was listed on Mr A's care plan as his "Primary Nurse" and created his care plan following his admission. There is no explanation of the role and responsibilities of a primary nurse in relation to individual patients. RN C does not believe that she was solely responsible for weighing Mr A. I accept that there was no evidence that RN C was solely responsible for weighing Mr A, and there was also no guidance to other staff about who was responsible for this.

82. However, RN C met with Mr A on 9 September 2014 and assessed him, and noted that following a recent hospital admission he had recent weight loss and was under weight. RN C did not perform a nutritional assessment for Mr A until 15 September 2014. The "Nutrition — Assessment and Management" policy stated that if a resident at admission had a history or physical condition that suggested that the resident was nutritionally compromised, a nutritional assessment was to be completed within 48 hours of admission. RN Russell advised that, due to his condition, Mr A met the criteria.

83. Bupa told HDC that the checklist stated that a nutritional assessment was to be completed within a week, and accepted that this may have caused confusion for the nurses. Bupa's instructions in this regard were unclear and confusing for staff.

84. I accept that there is no evidence that RN C was solely responsible for taking Mr A's weight. I also accept that there was conflicting instruction provided by Bupa to staff about when Mr A was due for his nutritional assessment when he arrived at the rest home, and that Bupa had no dietitian available at this time to whom Mr A could be referred by RN C. Accordingly, I find that RN C did not breach the Code.

Opinion: adverse comment — CM D

85. While I note that CM D was responsible for monitoring the provision of the clinical care provided and providing oversight of the clinical records, I am mindful of the training and support provided to her by Bupa — or the lack thereof. It is apparent from CM D's professional history that she had never previously held a role as a clinical manager, and had no experience with hospital-level care.

86. It is documented that CM D completed her orientation. It is also documented that CM D did not receive her initial training on "Nutrition and Hydration" until after the rest home ceased providing care to Mr A.

87. On 14 February 2015, CM D provided feedback to Bupa and stated: "A longer induction period shadowing a [clinical manager] would have been beneficial, particularly as I was not Bupa trained and I was going to a new build with no established systems in place."

88. In relation to the dates where there are limited entries in Mr A's progress notes, CM D stated:

> "During the time frames missing in the file, we would have been admitting 4–6 residents a week, with ongoing recruiting and orientating of new staff as the numbers increased. I was working as a caregiver, RN and trying to learn a new [clinical manager] role, without the mentorship I was promised."

89. I also note RN Russell's advice:

> "[The rest home] was a brand new recently opened Facility in [year] and it would be easy to consider the fault in the documentation is the responsibility of the Registered Nurses, the Clinical Manager and the Facility Manager who were responsible for [Mr A's] care. However such issues seldom are the responsibility of just one person or group …"

90. While I am critical of the care provided by CM D to Mr A, and the level of oversight CM D provided in relation to his weighs, nutritional assessments, and the level of

documentation, I accept that the environment, staffing levels, and the training provided by Bupa to CM D, especially considering her lack of previous experience, contributed to the deficiencies in CM D's level of oversight of the care provided at the rest home.

Recommendations

91. I recommend that Bupa:

a) Provide a written letter of apology to Mr A's family for its breach of the Code. The letter is to be provided to HDC within three weeks of the date of this report.

b) Conduct an audit of compliance with its Orientation Policy at the rest home for the preceding four months, and report the results of the audit to HDC within six months of the date of this report.

c) Conduct an audit of compliance with the nutrition and urinary tract infection policies for the past three months, and report the results of the audit to HDC within six months of the date of this report.

d) Consider establishing a policy for the development and opening of new rest homes to ensure that appropriate staffing numbers and appropriate staff training occur, and report back to HDC on this within three months of the date of this report.

Follow-up actions

92. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's and CM D's names.

93. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited, will be sent to HealthCert (Ministry of Health), the DHB and the Health Quality & Safety Commission, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from registered nurse Ms Julia Russell:

"**Introduction**

The purpose of this report is to assist in determining the level of nursing care [Mr A] received at [the rest home]. In reviewing his notes it is clear that [Mr A] was at the time of his admission already a very frail gentleman who had multiple co morbidities. [Mr A] left [the rest home] on the 15 November 2014 and was transferred to [Hospital 2] as a result of what appears to be an acute event while out with his family. In [the family's] initial letter to the Health and Disability Commissioner there are a number of complaints [and] concerns and this report will address the following matters:

1. Was the nursing care at [the rest home] consistent with the accepted standards?
   a. Care plans and assessments
   b. Documentation
2. The adequacy of the administration of showers, baths and other hygiene procedures.
3. The adequacy of BUPA's nutrition assessment process/policy.
   a. The adequacy of the administration of food and fluid to [Mr A]
4. Whether a referral to the GP was needed prior to 28 October 2014.
5. Whether [Mr A] should have been referred to the GP/hospital between the 30 October and 3 November 2014 when his condition deteriorated — if so identify who had the responsibility to refer to [Mr A]. NOTE whether [Mr A] should have been referred to the hospital in the same time frame [as] has been added as the result of this review.

Background

[Mr A] was admitted to [the rest home] on 8 September 2014 into premium level hospital care. Premium room rates vary across different providers and often are not related to the direct care a Resident is provided. For purposes of this report it is assumed that the premium room charge was not related to any offer of increased care provision. [Mr A's] admission to [the rest home] followed a prolonged period in [Hospitals 1 and 2]. It is evident from reviewing the statements from the Registered Nurses involved, progress notes, medication charts and care plan that [Mr A] had significant physical issues and also required a large amount of emotional support and encouragement as well.

1. Was the nursing care at [the rest home] consistent with the excepted standards? Please comment on the care provided by individual registered nurses if individual care was not consistent with accepted standards?

1a. Care plans and assessments

[Mr A] was admitted and a care plan was put in place. The assessments that would be expected to be completed — falls, skin etc were completed. However

the completed nutritional assessment including the mini nutritional assessment (MNA) was completed later — see 3. The Fortisip was not arranged prior to [Mr A's] admission and it would be expected to have been discussed as part of the nursing handover. Once the [rest home] nurses understood that Fortisip was required it was promptly obtained. It is worthy to note here that if there was another Resident using Fortisip at [the rest home] as was suggested then nursing staff would have probably accessed that for [Mr A] so there would have been no delay. [Mr A's] careplan and assessments meet the accepted standards, except for the MNA which is addressed in 3.

1b. Documentation

The Registered Nurses involved in [Mr A's] care wrote in his progress notes regularly, however there are a significant number of shifts/days where there are no recordings in the progress notes. There is no comment in any of the material received that acknowledges the notes were incomplete so it can only be assumed that BUPA staff have not realised that.

Days that there are no progress notes:

- on the night shift of the 12 October,
- the morning and afternoon of the 13,
- the morning of the 14,
- the entire day of the 15,
- the afternoon of the 16,
- the morning of the 17,
- the morning and afternoon of the 18,
- the entire day of the 20,
- the entire day of the 22,
- the morning of the 24 October to the night of the 27 October

Documentation is a key function of all Registered Nurses as identified in domain 2, competency 2.3 of the New Zealand Nursing Council Registered Nurse scope of practice document http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse. Domain 1, competency 1.3 states that overseeing the activities of those who report to RNs such as Enrolled Nurses and Caregivers is also their responsibility. In a long term care facility the recording of the general activities of daily living are recorded by the care givers and as indicated above there are significant gaps. The medication administration record has been reviewed for this same period and medication administration was not missed over this time frame. This is very fortunate and indicates [Mr A] was being seen by RNs several times a day. However, [Mr A] was a frail hospital level resident on a course of antibiotics as well as other medications and should have been seen for more than medication administration and given his health state, possibly had recordings from the RN who was responsible for him on a daily basis. In the progress notes and the BUPA letter 14 August 2014 there are references to [Mr A] moving areas however there are no dates given for these moves so it is not possible to know if they attributed to the lack of written progress notes.

BUPA has shared progress notes with both RNs and carers recording information so it is an example of very poor practice that this has occurred and is seen as a significant issue and is a serious departure from the standards. It is difficult to determine who is responsible for the absence of recording over much of the 10 day period. [The rest home] had a Facility and a Clinical Manager in place, the 14 August 2014, BUPA letter details that the Clinical Manager is the person who does the follow up with clinical matters for the Residents. [The rest home] was a brand new recently opened Facility in [year] and it would be easy to consider the fault in the documentation is the responsibility of the Registered Nurses, the Clinical Manager and the Facility Manager who were responsible for [Mr A's] care. However such issues seldom are the responsibility of just one person or group and the scope of this report does not provide for the thoroughness of investigation that this would require.

2. The adequacy of the administration of showers, baths and other hygiene procedures

The care plan advises that [Mr A] will have 2 showers per week; this would be a minimum as other showers may be required. [Mr A's] wife expressed concerns regarding showers and bathing and the level of recording about this appears inconsistent with the level of concern that should have been evident to the RNs and Clinical Manager. Given [Mr A's] state of health and the Family's concerns it could be expected that staff would have been instructed to ensure all details were included. On the afternoon of the 4 November there was an instruction for staff to document more detail regarding showering and washing and there was certainly an increased amount of detail in the progress notes after this date.

Progress notes are the record of the day to day life of a Resident [and] as they are missing for a significant period it is not possible to be able to fully comment on the care that was provided to [Mr A]. However in reviewing the progress notes that are available there are recordings of [Mr A] declining a shower and also receiving body washes. When reviewing the material that is available it is important to consider that [Mr A] had various dressings to his lower legs and sacrum (at different times) with one Nurse giving that as the reason he declined the shower on that day. Certainly [Mr A] seems to be uncomfortable sitting on various occasions which is certainly consistent with his frail condition. From the 8 September to the 15 November recorded in the progress notes are:

Shower offers	Body washes	Showers
3 recorded offers that were declined	19 body washes There are other references to all cares done (8) and change of pad which would have included a wash of that area.	6 showers

If [Mr A] had been a well man the care provided in this area is not consistent with accepted standards, however he was not, he had multiple dressings, one on his

sacrum, he experienced low mood and it seems difficult to motivate in this area. [Mr A] also experienced a number of infections and this lack of attention to basic hygiene has left the family wondering if this was a contributing factor to other issues that he experienced. It appears the greatest deficit here is in ensuring that the family understood why [Mr A] did not want to shower and ensuring they were aware of that and were even involved in encouraging him.

Given [Mr A's] health issues and if all the notes were available the level of departure from the standard in this area would be considered minor. Except that as at least 10 days of recordings are missing and using the premise that if it is not recorded it didn't happen this must then become a moderate departure from the standards on the basis the information is incomplete so a full assessment of the adequacy in this area can not be completed.

3. The adequacy of BUPA's nutrition assessment process/policy

BUPA's nutrition assessment process/policy was provided as part of the material for review [and] is a comprehensive document that directs the completion of a nutritional assessment within 48 hours of admission. The policy covers: assessment, nutritional requirements and dietary preferences, nutritional record, completing the MNA tool and the different actions to take when the tool has been completed. If there are concerns regarding nutrition then the policy directs utilising a nutrition recording form for weight management.

[Mr A] was admitted on the 8 September [and] the date on the Mini Nutritional Assessment was 16 September which does not meet the policy requirements. At the time of admission there was a nutrition assessment by [RN C] who commented that soft food was required and that [Mr A] had recently lost weight but did eat well. [Ms Russell stated that [Mr A] met the criteria for being "nutritionally compromised".]

In the letter from BUPA on the 14 August 2014 the writer acknowledges that the information regarding [Mr A's] nutritional requirements was unclear, some of which was the responsibility of [rest home] staff. The result of the MNA was recorded as 17 points. The policy states that a person would be immediately referred to their GP with an urgent referral to the dietitian. Given there was no dietitian the doctor could have been accessed to deal with the malnutrition or a follow up with the hospital dietitian.

In [RN C's] statement she recalls [Mr A] receiving and eating his meals and that he was gaining weight. She also notes the potential benefit of a signing sheet which provides all of the multi-disciplinary team assurance that the supplement is both offered and taken; this has since been put in place. It was recorded in the notes that a dietitian referral will also be done. As was explained in the 14 August 2014, BUPA letter there was not a dietitian available at that time, given there was no dietitian available the referral should have been to the GP or back to a [Hospital 2] dietitian. However the matter remains that [Mr A] was extremely malnourished and whilst he had initially gained weight — the weekly weighs

were not continued and they did not seek the support of a dietitian. This is a moderate departure from the standards of care and the standards expected of the Registered Staff and Clinical Manager who were caring for him.

3a. The adequacy of the administration of food and fluid to [Mr A].

Information is again compromised by the large gap in the October recordings. Given [Mr A's] overall condition food and fluid intake is critical to his wellbeing as [Mr A's] condition deteriorates so does his intake of food and fluid. Dehydration is a concern for many older people and it is evident in the progress notes that this was an issue that everyone wanted to address with [Mr A]. On the 4 November he received a 12 hour bag of subcutaneous fluids overnight which certainly seemed to improve his overall situation over the next few days.

The care plan includes an assessment of [Mr A's] preferences and states the type of food he requires and the assessment and planning were satisfactory. As described above over the first 3 weeks the increasing weight shows he was eating and drinking. There are plenty of comments in the progress notes regarding his intake, [Mr A] did not sleep well and regularly drank through the night. There is no indication that he ate during the night which is often a way to assist a resident to sleep with a sandwich or biscuit.

It is noted in the progress notes that when he transferred to [the rest home] [Mr A] weighed 50.6 kg, [Mr A] was weighed on the 21 September and it was recorded 53.7 kg. A further weigh on the 29 September [Mr A] is recorded in two areas at two different weights he was 55 kg and 55.6 on this date. As there are no further weights available after this date he achieved this increase in weight in 9 weeks. Which ever of these weights is correct it appears that the total 6 kg increase which equates to 11% increase in [Mr A's] overall body weight was achieved within the first 3 weeks of his admission. Unfortunately there is no further information regarding [Mr A's] weight. This does not meet the requirements of the care plan which state he will be weighed weekly. On 16 November 2013 his weight was recorded at [Hospital 2] as 52.4 kg. It is therefore apparent that the weight [Mr A] gained in the first three weeks he had lost at some point prior to his 15 November admission to [Hospital 2].

The care provided by individual registered nurses was not consistent with BUPA policy or the accepted standard. Whilst [rest home] staff were certainly aware of and recording [Mr A's] deterioration, the ongoing recording of his weight would have assisted them in considering what actions they could best take to support [Mr A] and his family. It does not meet the expected standard for the Registered Nurse who should have continued with recording the weights or the Clinical Manager who should have been monitoring [Mr A's] weight. Food and fluid are fundamental requirements for all, therefore these areas of food and fluid administration are seen as a moderate departure from the standard which [the rest home] should have sought to address with continuing to weigh [Mr A], ensuring the supplement was given and having a dietitian to work with.

4. Whether a referral to the GP was needed prior to 28 October 2014

[Mr A] saw the GP on the 16 October at which time a throat swab and urine sample was sent and a hospital appointment on the 21 October. Over this period of time he was on antibiotics so this would be a time of monitoring and assessment to see how things were going for him. However there are significant gaps in the progress notes at this time:

- on the night shift of the 12 October,
- the morning and afternoon of the 13,
- the morning of the 14,
- the entire day of the 15,
- the afternoon of the 16,
- the morning of the 17,
- the morning and afternoon of the 18,
- the entire day of the 20,
- the entire day of the 22,
- the morning of the 24 October to the night of the 27 October

From what is recorded [Mr A] seems relatively well and it is evident from the progress notes that [Mr A's] condition was changing. A course of antibiotics, nitrafurantoin was started on the 24 October so there would have been some contact with the GP prior to this date. The progress notes record a further urine spec was sent to the Lab on the 29 October which indicates concern that the antibiotics — nitrafurantoin — he had been taking had not cleared his urinary tract infection. Whilst the progress notes of the 28 October [for] [Mr A] record him as eating and drinking well on the same day [Mr A's] wife rang [the rest home] and requested an ASAP doctor visit regarding his sore throat. The Clinical Manager sent a fax to the doctor in response to [Mr A's] wife's request. The gaps in the documentation are of concern however with the information that is available it does not appear that a further GP visit was warranted prior to the 28 October and it appears that the standards have been met on this occasion.

5. Whether [Mr A] should have been referred to the GP between the 30 October and 3 November 2014 when his condition deteriorated — if so identify who had the responsibility to refer [Mr A]. NOTE whether [Mr A] should have been referred to the hospital in the same time frame [as] has been added as the result of this review.

Timeline:

29 October	[Mr A] recorded as not so well, confused — not drinking. Urine dipped and spec to the lab GP to be called or if the GP not available they will send [Mr A] to hospital [RN]
30 October	seen by GP at 830 am — GP advises not for hospital
2 November	[Mr A] deteriorating over this time. Afternoon RN records GP to be faxed next day
3 November	Planned family meeting and offer for family to decide to transfer

4 November	GP visit in the morning s/c fluids 500 ml overnight 6 pm–6 am, antibiotics started

It is evident in the notes — which are complete from the 30 October to the 3 November that [Mr A's] condition was deteriorating. The GP visited on the 30 October and notes [Mr A] has had a transfusion and looks better but that he is not for hospital. Over the next two days [Mr A] continues to be unwell. On the 2 November a call is received from [Mr A's] wife with her concerns and the RN on the afternoon of the 2 November 2013 records that the RN is to fax GP (on the next working day). This occurred and a meeting is planned for 6 pm on the 3 November which the family arrive for but Doctor is unable to attend.

Given the RN's lengthy notes they were clearly concerned about [Mr A's] deteriorating condition. The 3 November meeting with the GP had been postponed and a conversation between the family and the RNs that they — the family — could take him to the hospital. The family declined to do this and wait until the Doctor saw [Mr A] the next day. At this time a transfer to the hospital due to the lack of GP availability would certainly have been justified as it is clear that despite [Mr A] being a very frail and unwell resident, there was no advanced care plan or do not resuscitate in place as both [Mr A] and his family still wanted to be treated. The GP had said on the 30 October that [Mr A] was not for hospital and there is of course considerable pressure on Residential Facilities not to transfer to hospital (this is written without knowing what the [regional] situation is in regard to this). The scope of a New Zealand RN is that they are able to work as autonomous practitioners and are able to work and act to meet the requirements of the residents in their care. The 14 August BUPA letter describes the development of a [rest home] specific policy providing direction for RN around medical support. This indicates that [rest home] RNs were working in a constructive manner dealing with the GP issues they were facing. RNs offered the opportunity for the family to make the decision about a transfer to hospital and the family decided to wait until the GP came which was 8.30 am on the next morning. Given the involvement of the GP and the offer to transfer to hospital and the discussion with the family the level of care here is to an acceptable standard.

Further comments regarding the nursing care that [Mr A] received at [the rest home]?

The time of opening a new facility is busy and pressured with new Residents, staff, policies and procedures. Whilst there are areas that required improvement including the availability of the dietitian and the management of the Fortisip there were other positive actions occurring. These included strategies to keep [Mr A] safe such as a sensor mat being in place and the significant improvement on the documentation from the 30 October.

There is an on-going culture across New Zealand of aged residential care facilities having negative and speculative comments made by professional

colleagues regarding the care provided. Such comments were made around the care of [Mr A] — the Fortisip comments and the [Hospital 2] notes where the writer records [Mr A] was 57 kgs at the start of September, this was not the case as he was 50.6 kgs on the day of his admission. From the 14 August BUPA letter it is noted that on the 15 November when [Mr A] was at the 24 hour Emergency service and at [Hospital 2] there were no requests for his current clinical information from [the rest home] — this means they did not get the opportunity to provide clinical details which may have been of assistance to [Mr A's] care. These comments and attitudes are not helpful to the health professionals involved in this case, the RNs at [the rest home], but they also are not helpful to resident families who are already dealing with the tough decision about having a family member cared for in a long term care facility.

In conclusion the following areas of concern are seen to have met the standards:

1. Was the nursing care at [the rest home] consistent with the excepted standards?
   a. Care plans and assessments
2. The adequacy of the administration of showers, baths and other hygiene procedures
4. Whether a referral to the GP was needed prior to 28 October 2014
5. Whether [Mr A] should have been referred to the GP/hospital between the 30 October and 3 November 2014 when his condition deteriorated — if so identify who had the responsibility to refer to [Mr A]. NOTE whether [Mr A] should have been referred to the hospital in the same time frame [as] has been added as the result of this review.

Point 3. The adequacy of BUPA's nutrition assessment process/policy

The adequacy of the administration of food and fluid to Mr [the rest home]
Is the area where there are moderate departures from the standards expected.

Point 1b. Was the nursing care at [the rest home] consistent with the accepted standards?

b. Documentation

This is the area where there is a serious departure from the standards expected and this is predominantly related to the missing documentation. As stated in the body of this report it is the RNs and Clinical Manager who were responsible for ensuring documentation is completed. However given that this has occurred close to the time of opening and the significance of this issue it is beyond the scope of this report to more completely investigate and comment on the causes for this.

End of Report

Julia Russell, RN, MNPhil"

The following additional expert advice was obtained from RN Julia Russell:

"**Review of [rest home] rosters 1 Sept–29 December 2014**

The purpose of this report is to review [the rest home] staffing rosters in respect of the number of staff and the staff mix — mix of care staff, registered and enrolled nurses that worked 1 Sept to the 29 December 2014. Reviewing the rosters includes identifying occupancy and staff hours worked. What is not able to be identified from the rosters are: the specific needs of the residents being cared for, the impact on staffing by the admissions/discharges or deaths, the level of training the Registered Nurses (RNs), carers had or required. If it is assumed that all of the residents at [the rest home] were new to the staff then there is also time required for them to get to know new residents. In doing this it is necessary to review what determines the amount of staff required and provided in an area/facility. Documents reviewed include the:

1. [Rest home] rosters
2. BUPA policy on staffing requirements
3. National Aged Care Residential Agreement 2014 Section D 17.3 and 17.4 appendix 1
4. SNZ HB 8163:2005 Indicators for safe aged-care and dementia-care for consumers
5. Table 3 information of resident numbers per area and from information supplied by BUPA 'In terms of staff, 62 unique staff were employed (plus the FM), working a total of 18,160 hours (some estimation required due to fortnightly pays). This excludes 39 hours' worth of agency.'

The rosters cover the care provided to the hospital and residential areas — this is a blended area with both hospital and resthome residents, from the rosters it is not easy to determine who was provided care by which staff. The dementia unit was usually 8–10 full with 1 staff member per shift so the staff in that area would have been busy with their Residents and unlikely to be able to provide time into the hospital and resthome area. The dementia unit roster was provided and the hours have been included in the overall total of hours. The dementia unit would require input from a RN and this has not been factored in when considering the RN numbers. This may have been a role designated to the Clinical Manager. Overall there is not a lot of use of agency staff and most sick shifts are replaced.

Resident numbers

The admissions are included on the roster information and an occupancy table was provided — table 3 giving the overall numbers which confirms that the admissions were generally resthome or hospital. Resident numbers went from 33 — Sept 1 to 45 by the 29 December over 11 weeks. The total number of admissions was 26 which means there were 59 Residents in total cared for by the [the rest home] during this time (excluding dementia). In December the numbers of hospital and resthome residents was 40 this means that there were 19 people who were admitted but not included in the final Resident count, this is a lot of discharges/deaths over the time. For example in the week of the 22nd Sept where

there are 8 admissions noted on the roster, the 29 September roster has an overall increase in numbers of 2. The amount of work an admission and discharge incurs is significant. Table 1 was developed as a reference to review: number of admissions per week, staff hours per week, extra hours such as orientation or just extra hours that were added into the roster.

Table 1: Reference table of information collected on hours, admissions, discharges from the roster material provided

Weeks — date	**Number of residents**	**Admissions**	**Discharges**	**Hours Worked per day in hosp and resthome**	**Orientation Hours**	**Total Hours per week**
1–7 Sept	total 33	1		47 Carer 24.5 RN		329 171.5 164.5 (D) = 665 hrs
8–14 Sept	17 hosp/11 rest/ 8 dem total 36					329 171.5 164.5 (D) =665 hrs
15–21 Sept	17 hosp/11 rest/ 8 dem total 36	2	? 2			329 171.5 164.5 (D) = 665 hrs
22–28 Sept	19 hosp/12 rest/ 8 dem total 37	8	?7	Extra 5 hours worked	17.5	329 171.5 164.5 (D) = 665 hrs
29 Sept–5 Oct	16 hosp/13 rest/ 10 dem total 39	4	?2	52 Carer 24.5 RN		364 171.5 164.5 (D) =700 hrs
6–12 Oct	17 hosp/13 rest/ 10 dem total 40	1				364 171.5 164.5 (D) = 700 hrs
13–19 Oct	19 hosp/14 rest/ 8 dem total 41	6	3 from the info —			364 171.5 164.5 (D) = 700 hrs

20–26 Oct	total 45	4		52.5 Carer 24.5 RN		367.5 171.5 164.5 (D) = 703.5 hrs
27 Oct–2 Nov	+total 45	0		53 Carer 24.5 RN		371 171.5 164.5 (D) = 707.5 hrs
3–9 Nov	+total 47	0			67 extra hrs	707.5 hrs
10–17 Nov	+ total 47	0			40	707.5 hrs
18–23 Nov	+ total 47	0				707.5 hrs
24–30 Nov	+total 47	0		66 Carer 24.5 RN	52 hours + 3 hours on 30 Nov	462 171.5 164.5 (D) = 798 hrs
1–7 Dec	+total 49	0			63	798 hrs
8–14 Dec	+total 49	0			36	798 hrs
15–21 Dec	+total 49	0		74 Carer 39 RN — 15 of these could be RN or EN		518 273 164.5 (D) = 955 hrs
22-29 Dec	+ total 49	0			16	955 hrs

+ from table 3

Hours worked

Requirements for staffing are established using an organisation's own policies, the National ARC Agreement and the SNZ HB 8163:2005 Indicators for safe aged-care and dementia-care for consumers (this provides indicators which are now considered very outdated). The 2014 National ARC Agreement had some guidance for staffing as indicated in Appendix 2 and it was used as the basis for the BUPA policy on staffing hours — Appendix 1. In the 2017 National ARC Agreement there is no guidance regarding staffing hours provided at all. There is no mandated requirement for hours per resident day or other staffing factors — this is determined by the Facility, using its policy and knowledge of Resident acuity and need.

The BUPA roster is split into shifts mornings; afternoons and nights, there are shifts that are a variety of lengths — many 7.5 hours with some 4, 5 and 5.5 hour shifts. Carers and RNs work across the 3 shifts. The RN roles work an 8 hour shift and cover 24 hours per day — the afternoon shift appears to have a paid break so the number of hours exceeds 168 hours per week. There was also a Clinical Manager in place — this information is not provided on the roster it was part of the information provided for the July 2016 report.

BUPA has told HDC: 'In terms of staff, 62 unique staff were employed (plus the FM), working a total of 18,160 hours (some estimation required due to fortnightly pays). This excludes 39 hours' worth of agency.' Table 1 provides the approximate number of hours for this period both RNs and Carers is 11,826 hours in total with a further 302.5 hours of extra hours and orientation and the numbers of staff employed on the rosters provided was 49.

Reviewing hours in a roster, there are a number of ways to do this.

1. **Using staff numbers as a ratio to work out the number of Carers to residents.** Ratios for Carers to hospital residents are generally 1:5–1:7 and 1:10 for resthome residents. These ratios do vary across the day with the afternoon and nights having significantly less staffing as usually the morning shift is the busiest shift with the greatest load of activities and tasks required by both Carers and RNs. Given the resident numbers for September there would need to be 4 staff. There were on average 10 hospital residents this means that a carer and a RN would have looked after these people. This would have left the rest of the residents cared for by the other staff — a long shift and a short shift. As the numbers were increasing over the week of the 29 September there was an extra carer position added in the morning however this was worked one day of that week — although staff were orientating to the position. The extra 4.5 hours shift was in place the week of the 6 October. Staffing numbers increased in October as the numbers increased through to November requiring 3 staff for the hospital and 2 resthome. In December the overall numbers increased again with 4 staff working in the hospital area and 2 for resthome.

2. **Hours per resident per day**
   Table 1 provides the hours per resident day calculated from the September and October roster information which had Resident numbers on it, this does not clearly consider the breakdown of resthome and hospital Resident numbers. The information from BUPA — table 3 has also been added in the '( )' and the impact of the Clinical Manager's hours is also indicated. Table 2 only uses the information from Table 3 as there were no resident numbers on the roster for that period.

   However one of the useful aspects of this calculation is that it demonstrates that while total hours were increasing Resident numbers were too which means that actual increase in staff was minimal. The Clinical Manager hours have not been included in the calculation but identified separately. By the very

title this role has a clinical input in managing admissions, discharges and higher level clinical support and advice to the carers. If you add the hours per resident day for the Clinical role then it takes the RN hours to 1 hour per resident day for September and 0.92 for October. As the RN hours increase in mid December you see an increase in the hours per Resident day and if you again add in the Clinical Manager this increases the number of hours worked.

Table 1: Average occupancy from the roster information and hours per resident per day

Average occupancy number	Sept	Oct	Sept — Hours per resident day	Oct — Hours per resident day
Resthome	12	19	Carers 1.6 (1.75)	Carers 1.8
Hospital	16	15	RN 0.88 (0.9) *Clinical Manager adds a further 0.2 hours per resident day	RN 0.72 *Clinical Manager adds a further 0.2 hours per resident day

( ) indicates the use of [the rest home's] benchmarking information from table 3.

Table 2: Hours per resident day November and December using Table 3 information

Average occupancy number	Nov	Dec	Nov Hours per resident day	Dec Hours per resident day
Resthome	21	20.4	Carers 1.5	Carers 1.8
Hospital	16	19.5	RN 0.88 *Clinical Manager adds a further 0.2	RN 1.28 *Clinical Manager adds a further 0.2

Table 3: [The rest home's] benchmarking information of average occupancy

	Sep	Oct	Nov	Dec
RH	17	19.2258	21	20.3871
Hosp	10	14.1935	16.2667	19.5484
D3	7.97	9.06	9.80	9.00

3. **SNZ HB 8163:2005 Indicators for safe aged-care and dementia care for consumers**. Recently this has been discussed in a recent Labour and Greens Aged Care Inquiry. As stated in the title this information the requirements are indicators only. In using the indicators from this document from Appendix 3

— table 1 page 21 SNZ HB 8163:2005 which identifies the residents as high dependency/clinically stable — where there must be an RN on duty at all times as was the case in the [rest home] blended area and assuming as in point 1 how the Carers and RNs were working across the Resident group. The number of carer hours allocated on this table comes from the same document however the Clinical staff at [the rest home] may have considered their Residents required less input than that.

[1] https://greypower.co.nz/wp-content/uploads/2017/09/Aged-Care-Report-Sep17.pdf

Table 4: Created from Table 1 Page 21–22 SNZ HB 8163:2005

	Carers hours per resident per week	RN hours per resident per week
Resthome	12	3.5
Dementia	14.5	2
Hospital	16.5	8

Because it is not possible to look at the hospital and resthome areas separately staffing numbers for September Carers and RNs in the hospital and residential areas are below what the indicator recommends for Carers but above what it recommends for RNs. However when you add the dementia unit hours for September the overall hours are more than the recommended amount.

In October there is no increase in the RN hours across the area and as numbers go up there is no longer sufficient RN cover using the above scenario. However the Clinical Manager is not included in the RN hours so their 40 hours per week would address this deficit for October and November. In October there is a minor increase in Carer hours however this indicator shows that the Carer staff numbers are still somewhat less than the ideal number 59 more care hours would be indicated.

Through November and early December RN staffing didn't increase until the week of the 15 December so the Clinical Manager's hours would cover most of the requirement. As well as this the increased Carer hours did not meet the indicator numbers until the increase in mid December even if you include the Dementia Unit numbers. Given the small number of staff in the Dementia area — 1 on each shift it is difficult to imagine they can be overly supportive to the hospital and residential area.

In conclusion this review included reviewing the:

1. [Rest home] rosters,
2. BUPA policy on staffing requirements
3. National Aged Care Residential Agreement 2014 Section D 17.3 and 17.4 — attached

4. SNZ HB 8163:2005 Indicators for safe aged-care and dementia-care for consumers
5. Table 3 information of resident numbers per area

BUPA provided a total of hours worked over this time (18,160) and staff employed (62). Table 1's summary total of hours identifies 118265 hours in total with a further 302.5 hours for orientation and extras. These numbers are a significant difference from the total hours paid by BUPA and numbers staff employed. However BUPA's total presumably included other associated staff kitchen etc.

In New Zealand there are no mandated requirements for staffing levels with guidance provided in the BUPA policy (excerpt attached as Appendix 1) details how staffing levels are determined and their policy consistent with the National ARC Agreement attached as Appendix 2. Rostered hours must be considered in association with the clinical judgement of the Clinical Manager and staff considering the acuity of the Residents and the capability and capacity of the staff and the fluctuations in occupancy as admissions and discharges take a considerable amount of time. The Clinical Manager would have assisted with this large clinical work load so it is essential to include these hours in the overall totals.

The hours on the rosters provided exceed the information in the policy and the ARC agreement. The hours per resident day calculations in tables 2 and 3 demonstrates that despite increases in hours the overall ratio of staff was not increasing despite the total number of Residents increasing by 16 from 1 September to the 29 December. In reviewing them against the SNZ HB 8163:2005 Indicators for safe aged-care and dementia-care for consumers which although has limited application in today's environment is a useful yard stick which demonstrates that over time this staffing did not keep up with the Resident numbers. The SNZ HB 8163:2005 Indicators for safe aged-care and dementia-care for consumers identify minimum numbers of staff requirements. The Labour and Greens Aged Care Inquiry 2017[1] states that '[t]he existing standards for residential care coverage were agreed in 2005 as recommended guidelines. The guidelines include standards for staffing by care workers and nursing staff. They are now out of date and are not being consistently implemented.'

Given that there was [this] complaint which indicated that [Mr A] was very frail and had high needs from the time he was admitted, [and] the number of admissions and discharges from the area it seems that the ability to keep up with the care provision as well as the needs of new staff with new Residents was compromised at times. Especially considering that the 2005 Staffing Indicators which are considered outdated were not met over the months of October and November as the numbers increase from 27 in September to 36 December. BUPA responded to the increased number of hospital and resthome Residents in late November with the amount of staffing for both Carers and RNs increasing and

new staff who as time progressed would have been well familiar with new Residents and processes."

[1] https://greypower.co.nz/wp-content/uploads/2017/09/Aged-Care-Report-Sep17.pdf

Appendix 1: Excerpt from the BUPA Staffing Rationale Policy

Implemented: 10/05
Latest Review: 04/13
Approved

Staffing Rationale

Subject:	Staffing Rationale
Reviewing body:	Quality and Risk
Objective:	To ensure staffing levels and skill mix provide safe service delivery

Rest Homes

- All care homes (up to and including 30 subsidised residents) will have at least one care staff member on duty and one care staff member on call at all times.
- All care homes (with more than 30 subsidised residents) will have at least two care staff on duty at all times
- All care homes (with more than 60 subsidised residents) will have at least three care staff on duty at all times
- These are minimal requirements and there may be a need for the Care Home and Clinical Manager, together with the Operational Manager, to amend these requirements based on the lay out of the building or any identified increased care needs of residents
- A Registered Nurse is engaged to carry out the role required in clause D17.3 (e) of the ARRC Contracts

Hospitals

- A Registered Nurse must be on duty at all times - in any situation where this is not achievable the risk will be managed by
  - i) A Registered Nurse providing on call cover in close location to the care home - with access to current and relevant resident clinical information
  - ii) Access to GP back up
  - iii) Access to emergency services / secondary services
  - iv) Documented guidance for staff re accessing on-call nurse / advice / information / support/ assistance
  - v) Consultation with DHB - as appropriate by the Regional Operations Manager
- A minimum of 2 care staff on duty at all times

Appendix 2: Staffing requirements from National ARC agreement 2014

D17.3 Rest Homes

a. In every Facility where there are:

i. 10 or fewer Subsidised Residents, there must be a Care Staff member On Duty at all times;

ii. up to (and including) 30 Subsidised Residents, there must be one Care Staff member On Duty and one Care Staff member On-call at all times;

iii. more than 30 Subsidised Residents, at least two Care Staff members shall be On Duty at all times;

iv. more than 60 Subsidised Residents, at least three Care Staff members shall be On Duty at all times.

D17.4 Hospitals

a. In every Hospital:

i. at least one Registered Nurse shall be On Duty at all times;

ii. the distribution of Care Staff over a 24 hour period shall be in accordance with the needs of the Subsidised Residents as determined by a Registered Nurse. A minimum of 2 Care Staff are required to be On Duty at all times;

iii. the layout of the Facility must also be taken into consideration when determining the number and the distribution of Care Staff required to meet the needs of the Subsidised Residents under clause D17.4(a)(ii).

Appendix 3 Table 1 Page 21-22 SNZ HB 8163:2005

Table 1 – Nursing specifications for consumer aged-care registered nurse staffing hours (EAP)

Work load level	Complexity consumer description	RN inputs	Frequency	RN hours per consumer per week
A	Frail ambulant clinically very stable	Assessment Care plan review Complex nursing intervention processes Care review / evaluation	No more frequently than three monthly; Processes from Appendix C1, if there are staff available that have been assessed as competent by a registered nurse; One process only from Appendix C2 must be undertaken by a registered nurse.	1 hour
B	Medium dependency clinically stable	Assessment Care plan review Complex nursing intervention processes Care review / evaluation	More frequently than three monthly but no more frequently than monthly; Processes from Appendix C1, if there are staff available that have been assessed as competent by a registered nurse; One process only from Appendix C2 must be undertaken by a registered nurse.	2 hours
C	Low to medium dependency Clinically stable has behaviour that requires a secure environment	Assessment Care plan review Complex nursing intervention processes Care review / evaluation Secure environment Nursing input for behaviour management Complex nursing intervention processes	Dependent on behaviour not more frequently than daily required; May be as frequent as once daily but not continuous over 24 hours; Not more frequently than once a day.	3.5 hours Must be a RN on duty daily
D	High dependency Clinically stable and/or has mildly disruptive behaviour	Assessment Care plan review Complex nursing intervention processes Care review / evaluation Assessment Care Plan review Complex nursing processes	More frequently than monthly but less frequently than weekly; Needs more than one process from Appendix C2.	8 hours Must be a RN on duty at all times