Rest Home Company

Nurse, Ms E

General Practitioner, Dr F

A Report by the Deputy

Health and Disability Commissioner

(Case 05HDC15501)

Parties involved

Mrs A	Consumer
Mrs B	Complainant/Consumer's daughter
Mrs C	Complainant/Consumer's daughter
Mrs D	Complainant/Consumer's daughter
The Rest Home	Rest home
Rest Home Company	Rest home company
Rest Home/Hospital	Rest home/hospital
Ms E	Nurse leader
Dr F	General practitioner
Ms G	Site manager
Ms H	Registered nurse
Ms I	Registered nurse
Mr J	Chief executive officer, Rest Home Company
Ms K	Rest home admissions coordinator

Complaint

On 28 October 2005, the Commissioner received a complaint from Mrs B about the services provided by a rest home to her mother Mrs A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by the rest home between 16 September and 7 October 2005.*

- *The appropriateness of the care provided to Mrs A by general practitioner, Dr F between 16 September and 7 October 2005.*

An investigation was commenced on 2 February 2006. On 23 May the investigation was extended to include the rest home Nurse Leader Ms E, as follows:

- *The adequacy and appropriateness of the care provided to Mrs A by nurse leader, Ms E between 16 September and 7 October 2005.*

Additionally, Mrs B was concerned about a male resident at the rest home wandering into Mrs A's room and taking her personal possessions. On one occasion, the resident assaulted Mrs A. Mrs B was also concerned that she found her mother's medication on the floor of her room. These matters will be addressed in the "Additional Information" section of the report.

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This investigation has taken over 12 months. The principal reason for this is that the investigation was extended to include the Nurse Leader Ms E. Additionally, one of the independent experts was unable to provide advice within the usual time frames because of her work commitments.

It also took three months and two follow-up contacts to elicit a response from Dr F to the complaint and investigation.

Information reviewed

Information received from:

— Mrs B
— Mrs C
— Mrs D
— Ms G
— Mr J, Chief Executive Officer, rest home company
— Dr F
— Ms E
— Ministry of Health.

Mrs A's clinical records were obtained from the rest home. The Commissioner obtained advice from independent experts, general practitioner Dr Tessa Turnbull, and registered nurse Ms Lesley Spence, who have specialist knowledge in the care of the elderly.

The Commissioner's independent clinical advisor, Dr Stuart Tiller, also provided some advice.

Information gathered during investigation

Overview

Mrs A, aged 86 years, transferred from a rest home/hospital to the rest home in August 2005. Three weeks after her admission to the rest home, Mrs A developed a cough. She was assessed by the visiting doctor, Dr F, who initially prescribed a cough elixir. However, Mrs A's cough persisted and became "productive" and nine days after he prescribed the cough elixir, Dr F ordered blood tests and instructed the staff to provide adequate fluid and analgesia to Mrs A. Mrs A's condition continued to deteriorate, and

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on 3 October Dr F ordered a chest X-ray and commenced her on antibiotics. The X-ray confirmed that Mrs A had bronchopneumonia. Dr F ordered the prescribed treatment to continue. Mrs A's condition continued to deteriorate, and on 7 October Dr F arranged for her to be admitted to hospital. On 12 October 2005, Mrs A was transferred back to the rest home/hospital on her discharge from hospital.

During her stay in the rest home, Mrs A was visited by her three daughters, Mrs B, Mrs C and Mrs D.

The rest home
The rest home is owned and administered by a rest home company. References to the rest home in this opinion include the rest home company. Ms G is the Site Manager for the rest home. Ms E was employed as Nurse Leader at the rest home from July 2005.

Chronology

August 2005
Mrs A was transferred from a rest home/hospital and admitted to the rest home dementia unit for a short-term stay on 22 August 2005, for assessment and management of a recent deterioration of her mood and suicidal ideation. The rest home/hospital was not able to provide this type of care.

On her admission to the rest home, Mrs A was assessed by registered nurse Ms H, who noted in the "Initial/Pre-Assessment and Support Guide" that Mrs A's admission was for "Short stay in Dementia Stage III unit. If behaviours settle — for reassessment back to rest home placement." Ms H recorded in the nursing notes that Dr F had been notified of Mrs A's admission and asked to visit the rest home to formally admit her and review her medication.

The rest home registered nurses are responsible for completing a "Resident Assessment" form for all new patients within 24 hours of admission. Nurse Leader Ms E stated that this form acts a "mini care plan" until a comprehensive care plan can be commenced.

Ms E stated that the "Resident Assessment" form Ms H completed identified Mrs A's allergies, falls risk, skin tears, and lower limb oedema. Ms H recorded in the "Resident Assessment" form:

> "Multi meds [medications], multi-sensitivities; Clinical Nurse Leader: Query raised re psychotropics ↑ [increased] multi & sedatives. Significant medical history. To observe for s&s [signs and symptoms] of delirium — suicidal ideation."

Ms E stated that the admitting registered nurse or enrolled nurse is also responsible for commencing a Care Plan for all newly admitted residents. If presented with any problems, the nurse should discuss these with the Nurse Leader.

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Dr F reviewed Mrs A on 24 August and noted that Mrs A's night-time sedation was to be decreased. He asked the nursing staff to organise tests to monitor Mrs A's digoxin (heart medication) blood levels. Five days later the results of these tests were reported to Dr F who entered the results in the clinical record. It appears that Mrs A's digoxin blood levels were satisfactory as Dr F did not order any change to her treatment and only noted that she was anaemic.

During the remainder of August, nursing staff reported that Mrs A was unsettled at night and although she had swelling to both feet, she appeared reasonably stable.

September 2005

On 2 September, Mrs A was reviewed by Dr F because a lesion had developed on her left leg that required dressing. He recorded that there was no apparent infection in the leg and asked the nursing staff to continue to dress the leg as required.

At 11pm on 5 September, Ms E was called in to see Mrs A, who had sustained a skin tear to her left leg sometime during the afternoon shift. The wound was cleaned and dressed with Steri-strips, Telpha and Opsite. An "Incident" form was completed, recording the injury and the action taken.

On 9 September, Dr F saw Mrs A again, and noted her increased confusion and incontinence. He recorded that she looked well but appeared drowsy. He decided to decrease her antipsychotic medication and stop her diuretic. Dr F noted that Mrs A was to have a urine specimen collected for laboratory analysis.

The nursing progress notes, for the afternoon of 9 September instruct the staff to test Mrs A's urine for infection. The notes also record that her medications had been changed and the changes were faxed to the pharmacy.

The nursing progress notes, completed by an unidentified healthcare assistant, for the night of 11/12 September, state:

> "[Mrs A] confused but assisted with toileting and assisted back to bed. Drinking fluids in between and complaint about both legs being sore. Moist coughing noted @ times. Dipstix [urine test] completed — leucocytes 125 +++, nitrate neg., protein trace, glucose neg, blood — trace 10. MSU [mid stream urine] sent to lab today."

That afternoon the staff noted further coughing and advised the staff on subsequent shifts to observe Mrs A.

Over the following three days the nurses again reported that Mrs A had a moist cough.

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On 19 September, Mrs A was seen by Dr F, who prescribed a cough elixir for Mrs A after noting that she had been coughing over the weekend. That afternoon the nursing staff recorded: "Coughing still but Dr said chest was clear". Mrs A was given cough medicine that relieved her coughing during the night. The following day Mrs A was still troubled by a persistent cough.

There are no records of Mrs A's condition between 20 and 23 September. On 26 September she was noted to be "very confused".

Ms E stated that routine practice for any registered nurse in this situation would be to take the resident's vital signs — temperature, pulse and blood pressure — and record the same. The registered nurse should leave instructions regarding the resident's care in the clinical notes, and at hand-over request that the recordings continue with a view to referring the patient to the doctor if the resident's condition deteriorates.

On 28 September, Mrs A was seen by Dr F, who noted that her chest was clear, but that her heart rate was irregular. Dr F ordered a blood test to check the condition of her heart. When Dr F received the results of the blood test that evening and found that there were no immediate concerns, he instructed the nursing staff to continue with Mrs A's charted treatment.

The following day, 29 September, Mrs A was noted to be "wheezy in the night". She appeared to be "chesty" and was complaining of burning in her throat. Registered nurse Ms I took Mrs A's vital recordings at 9.30am, noting her temperature to be 37.1°C. Ms I recorded in the nursing notes that Mrs A was to be encouraged with fluids, and have regular analgesia. Ms I recommended that Mrs A should be seen by Dr F the following day.

On 30 September, Dr F reviewed Mrs A and noted, "chest creps at right base", and that she had an elevated respiration rate of 26 to 28 breaths per minute. (A normal respiration rate for an adult is around 18 breaths per minute.) He prescribed the antibiotic doxycycline 100mg twice daily for seven days, and instructed staff to "Review if worsening over the weekend".

October 2005

Mrs A commenced the doxycycline at 1.30pm on 1 October. The nursing notes state that Dr F was to be informed if Mrs A's condition deteriorated. That afternoon, Mrs A's daughter Mrs C (who held Enduring Power of Attorney for her mother) was informed that Mrs A was "not well". The progress notes for 6.45am on 2 October instructed staff to "observe" Mrs A and provide "plenty of fluids". The note appears to have been recorded by a health care assistant.

At this time, Mrs B became concerned about her mother. Mrs B recalled:

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> "Over a period of two weeks her health got increasingly worse, we expressed our concerns to the manager of the nursing home, [Ms K], but we were told that [Mrs A] was in fact eating and drinking well. I knew for a fact that she was not. When her family were with her, she would not initiate any form of nutritional intake herself and her medication was lying on the floor."

The rest home Site Manager, Ms G, stated that "Ms K" is the rest home Admissions Coordinator. Ms K does not recall Mrs B making a complaint.

Mrs A was still unwell on 3 October, and Dr F was called in to review her. He recorded her temperature as elevated at 37.2°C and recorded that Mrs A "looks weak". He could not detect any abnormal lung sounds but found that she had decreased air entry to the base of her left lung. Dr F ordered a chest X-ray, and instructed that Mrs A was to continue on the doxycycline and also to start an additional antibiotic — Ciprofloxin 500mg twice daily for seven days.

Mrs C was notified that Dr F had been to see her mother and had ordered a chest X-ray.

The chest X-ray was taken at 1pm. The result, faxed to Dr F, reported bilateral basal bronchopneumonia with right lower lobe collapse. The nursing staff encouraged Mrs A to have extra fluids and encouraged her to take small amounts of soft food. She was assisted to the toilet and appeared to be coughing less.

Dr F reviewed Mrs A again on 5 October, noted that she was improving, and instructed the nursing staff that Mrs A was to complete her course of antibiotics.

The following day, Mrs A was refusing food and fluids. Ms I instructed staff to encourage her to take extra fluid, and to keep her on bed-rest because her feet were still swollen. Ms I also recorded that that there was a skin tear on Mrs A's left calf that was inflamed and required a Steri-strip dressing. Ms I questioned whether this was an "old" skin tear.

Mrs B stated:

> "Whilst visiting with my daughter, Mum was very uncomfortable and managed to say that it was her bottom that was sore. My daughter and I lifted her and found that she had an extremely reddened sacrum almost to the point of breaking down. When I spoke to the nursing sister she entered the room, handed me some cream and a rubber glove and left. I assumed I was to apply the cream [and] with the help of my daughter we did."

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Ms G followed up Mrs B's complaint letter to this Office by speaking to the registered nurse on duty that day. (Ms G did not identify the nurse). The nurse confirmed that she invited Mrs B to apply the cream to her mother's sacrum, and there was no objection to the suggestion. Ms G said that it is not unusual for family members visiting residents at the rest home to like to assist with the nursing care.

On 7 October, Dr F reassessed Mrs A. He noted that she had deteriorated in the previous 24 hours and that she had a "reddened" wound to her left calf. He arranged to admit her to a public hospital. Mrs A's family were informed that she was to be transferred.

During her admission to the public hospital Mrs A was reassessed as requiring hospital level care. She was discharged from the hospital to her previous rest home/hospital on 12 October 2005.

The rest home policies
Ms G advised that during the time that Mrs A was a resident at the rest home new policies were being implemented across the organisation. Nursing Staff were being introduced to the new policies, but the old policies were still being supported operationally until the new policies could be fully implemented.

The systems in place at the time to support and ensure delivery of a quality service (that were being reviewed) included daily nursing handover reports, weekly/fortnightly Nurse Leader/registered nurse meetings and regular key team meetings, development of a quality committee, and input from the rest home company.

Site Manager
The job description and specifications for the position of Site Manager (updated August 2005), state that the manager is "accountable for the management and development of quality, client focused services for older adults for [the rest home company]". The principal responsibilities and associated duties of the position, in relation to the clinical area, are:

"• Ensuring the implementation of all organisations policies relating to clinical practice
• Ensuring clinical compliance in conjunction with Group Quality/Clinical Officer and Nurse Leaders."

Nurse Leader
The job description and specifications for the position of Nurse Leader — Rest Home, Nurse Leader — Hospital/Dementia (updated August 2005), state that the Nurse Leader "will be responsible for leading the clinical support teams to deliver quality support for older people within the assigned area of the facility". The relevant responsibilities and associated duties of the position are:

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"2. Working with the Group Quality and Clinical Manager and the Site Manager to ensure the quality and standards of clinical practice within the assigned area of the facility.

- Evaluating clinical practice delivered in the facility
- Identification of clinical issues that are required to be addressed
- Implementation of all organisational policies related to clinical practice
- Monitoring and coaching staff to ensure they are working in a manner consistent with contemporary nursing practice."

Ms E stated:

"In July 2005, I was approached by management who offered me the position of Nurse Leader at [the rest home]. As this site had seen many managers over the past few years, I was reluctant to take up the position. However, I agreed, but as acting Nurse Leader for two months — August and September. The Site Manager had only just joined the team in May, so during that time everything was very new to us. I signed as permanent staff in October. My brief from management was:

* Restructure the roster
* Update systems
* Introduce new policies
* Bring documentation up to standard
* Provide direction for staff.

During these months, I was met with much resistance. I was aware that change brings resistance and had several resignations from health care assistants who were not prepared to work with new rosters. However, my focus was on holistic care to all the residents and this could only be achieved by placing the staff with the relevant training in the specialised units. Several of the trained staff at this time were not supportive as there were many changes to systems and documentation. However, with the support of the Site Manager, I continued to implement change, [such as] Care Plans."

Additional information

Mrs B's additional concerns
Mrs B expressed concern about other aspects of the service provided by the rest home to her mother. She stated that a male resident was allowed to wander unsupervised into her mother's room, sometimes taking her mother's possessions. On one occasion he had physically injured her. Mrs B was concerned that staff instructed her to go to this man's room to retrieve her mother's possessions.

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Mrs B also expressed concern about finding her mother's medication lying on the floor in her room.

The rest home Site Manager Ms G responded to Mrs B's concerns on 1 December 2005. Ms G stated:

> "**1. Other resident wandering into [Mrs A's] room**
>
> [Mrs B] has suggested that this resident was allowed to wander into [Mrs A's] room. It is not the practice in [this unit], for nursing staff to allow this to happen. Every precaution has been taken to prevent residents wandering into another resident's room. However, it appears that this did occur, and as a result [Mrs A] was distressed. The resident in question does have a gentle personality and has never shown any aggressive behaviour during his stay with us. We regret that [Mrs A] was distressed over this. Our systems and processes have been reviewed in light of this and nursing staff advised to take additional precautions with residents who are likely to wander. This includes specific activities for these residents at certain times of the day.
>
> …
>
> **3. Medication on the Floor**
>
> [The rest home] policy is that the RNs supervise the taking of medication to prevent the resident from refusing. Nursing staff have been addressed about this incident that [Mrs B] raised. Further to this, medication rounds have been reviewed also in the last few months and a superior system was implemented in November [2005]."

Independent advice to Commissioner

Expert advice was obtained from general practitioner Dr Tessa Turnbull and nursing advisor Lesley Spence. Their advice is attached as Appendix 1 and 2.

Response to Provisional Opinion

Ms E

Ms E stated that she had accepted the position as Nurse Manager at the rest home with "great trepidation", but was assured by the Operations manager that she would be given support by the management team "to turn [the rest home] around and take it in

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another direction". The Operations Manager admitted to Ms E that this was a "massive undertaking as [the rest home] was her worst performing site".

Ms E stated that soon after accepting the position in July 2005, the Operations Manager became seriously ill and was not able to provide the anticipated support. At about this time, the administrator responsible for the rosters and payroll and the cleaning supervisor resigned. Ms E had to take up aspects of their roles. She also took over the ordering, distribution and assessment of all incontinence products from one of the registered nurses as she felt the RN's time would be better spent training caregivers and updating care plans. Ms E stated that she tried to update policies and procedures but was met with opposition from some quarters, in particular one registered nurse who went out of her way to make things difficult. When Ms E recommended that this nurse read the policies and make a judgement call, the response was: "What is the point, you keep changing them." Ms E stated that she began to feel that she was losing control. She emailed these issues to the Site Manager, Ms G but was met with hostility. There was one occasion when Ms G's hostile verbal reaction to Ms E's concerns was overheard by residents and staff in the foyer. The Site Manager later apologised to Ms E.

Ms E stated:

> "I am not disputing these findings as I did not perform the role that was expected of me for whatever reasons. I failed in providing the care of an old lady that was entrusted to me and I will have to live with that and the consequences. … "

The rest home

Ms G responded for the rest home stating:

> "Ms Spence has identified a number of issues in her expert advice report that [the rest home] failed to address. Since receiving the complaint regarding the care of [Mrs A], [the rest home] has undertaken actions to address the same issues identified.
>
> As identified in the report the organisation has systems, written policies and procedures in place to provide guidance to staff on issues relating to good care of residents. A review of compliance to these policies was undertaken by the newly appointed National Quality Manager, this review found that compliance was inadequate. As a result corrective actions have been put in place. Considerable work has gone into improving care, documentation, communication, nursing staff performance, education and clinical monitoring since receiving the complaint.
>
> Furthermore, there have been significant ownership and organisational changes during the past 12 months that have resulted in a greater focus and accountability

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being place on the delivery of high quality care at all [rest home company] facilities, including [the rest home]. This accountability is being supported by the appointment within the organisation of some senior positions that were not present pre-2006. These include the following — [a Chief Operating Officer, a National Quality Manager, two Regional Managers, a National Development Manager and a National Maintenance Manager].

The investment in skilled and experienced managers has provided increased support and guidance to the facility managers within the group. Reporting and surveillance processes have been implemented that ensures compliance to the company standards and that contractual obligations are being met."

Ms G went on to detail the changes that have occurred in response to this complaint. Full details can be found at Appendix 3.

Ms G concluded:

"We sincerely regret that [Mrs A] did not receive satisfactory care at [the rest home]. We acknowledge that communication was poor. Good communications along with compliance to [rest home company] policies could have prevented [Mrs A] and her family unnecessary distress.

We have addressed the issues with considerable work going into improving resident care. We are confident the systems and processes that have been implemented enable a solid foundation to provide consistency of quality care. We will continue to build quality and build a culture of quality improvement.

[The rest home company's] stated vision is to be the leader in senior living in New Zealand and this encompasses the provision of high levels of care to the residents entrusted to our care. The resources and investment has been and will continue to be, made so that this vision is attained."

Dr F

Dr F confirmed that during 2005 changes were made to the [the rest home] management and nursing practice. He stated: "[An agency] had been contracted to specifically provide a more comprehensive service which does cover 24 hours, 7 days a week encompassing regular ward rounds. I was the ward round doctor over this particular period."

Dr F stated that Mrs A presented with a long and complex medical history and that his aim was to "get a handle on this bearing in mind that the general clinical picture [was] of decline". He said that the role of ongoing medical management in these cases is a "balance of all different clinical problem areas and that these will continue to change and evolve".

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Dr F noted that there is a clear "feeling" in this report that Mrs A should have been treated earlier for her cough when it was first noted in the nursing records in mid-September 2005. He said that moist coughs were a very common symptom in the rest home Dementia Unit throughout the winter and spring of 2005. The majority of these patients, some of whose coughs persisted up to eight weeks, were treated as having a viral infection and given symptomatic support. Those patients with infective signs were treated with antibiotics and other appropriate medication. Acutely unwell patients were transferred to a public hospital.

Dr F stated that Mrs A remained stable until the last days of September 2005. Therefore, there were no grounds to treat her differently prior to 28 September. He said that a chest X-ray is not an automatic investigation for patients in rest homes and aged care hospitals, "the more usual is treatment followed by clinical progress and decisions made according to response".

Dr F agreed with Dr Turnbull's comments that patients should be treated in the private institutions where they are being cared for, but he acknowledged that instances occur when the family insist on hospital admission contrary to the advice of the general practitioner or hospital doctor.

Dr F stated that he spoke with the family from time to time when he called to see Mrs A, but he did not talk to them between 29 September and 7 October. He accepted that this was an oversight on his part. He said that if he had spoken to the family at that time he would have explained his rationale for his treatment decisions.

Dr F stated:

> "Hindsight always can colour the perception of the course of events, but the reality is that clinical decisions are made on a day to day basis. [Mrs A] will continue to have her multiple medical problems. I feel it would be in her best interest to manage her medically at the private hospital institution and avoid repeat public hospital admissions. … [The agency] continues to provide medical services to [the rest home]. We deal with the ongoing clinical care and acute problems as they occur. I have no concerns with the nursing staff and their ability to deal with the clinical issues."

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Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

Other Relevant Standards

The Medical Council of New Zealand's *Good medical practice — A guide for doctors* (2004) states:

"Medical care

Good clinical care

2. Good clinical care must include:

- An adequate assessment of the patient's condition, based on the history and clinical signs, and an appropriate examination
- Providing or arranging investigations or treatment when necessary
- Taking suitable and prompt action when necessary."

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

"4.0 Management of Nursing Care

The applicant manages nursing care in a manner that is responsive to the client's needs, and which is supported by nursing knowledge, research and reflective practice.

Generic Performance Criteria

The applicant:

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2.1. Uses an appropriate nursing framework to assess and determine client health status and the outcomes of nursing intervention.

…

4.3 Obtains, documents and communicates relevant client information.

4.4 Assesses and provides individualised nursing care based on appropriate knowledge, research and reflective practice.

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

4.6 Prioritises nursing actions to ensure effective and safe nursing care.

…

4.11 Directs, monitors and evaluates the nursing care provided by nurse assistants/enrolled nurses.

…"

New Zealand Health and Disability Sector Standards (NZS 8134:2001) published by the Ministry of Health states:

"**Part 2 Organisational Management** …

Quality and Risk Management Systems …

Standard 2.2 *The organisation has an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles.*

Criteria *The criteria required to achieve this outcome include the organisation ensuring:*

…

2.2.1 Relevant standards are identified and implemented to meet current accepted good practice in the relevant service area or setting.

…

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Standard 2.7 *Consumers/kiritaki receive timely, appropriate and safe service from suitably qualified/skilled and/or experienced service providers.*

…

C2.7.3 *This may be achieved by but not limited to:*

(a) Ensuring appropriately qualified/skilled service providers are available to provide the service where professional expertise is required;
(b) Ensuring service provision reflects an appropriate skill mix combining both knowledge and experience;
(c) Ensuring adequate and appropriate supervision/support is provided where required;
(d) Ensuring suitably experienced service providers are available to provide the service.

…

Part 5: **Managing Service Delivery** …

Outcome 5 *Consumers/kiritaki receive services in a planned and co-ordinated manner that comply with legislation and meet the needs of consumers/kiritaki.*

…

Recording Systems

Standard 5.2 *Consumers/kiritaki records are accurate, reliable, authorised and comply with current legislative and/or regulatory requirements*."

Opinion

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

Opinion: Breach — Ms E

As Nurse Leader, Ms E was responsible for leading the clinical support teams. She was required to work with the Group Quality and Clinical Manager and the Site Manager to ensure the quality and standards of clinical practice at the rest home. This included evaluating the clinical practice delivered, identifying clinical issues needing to be addressed, implementing organisational policies related to clinical practice, and

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monitoring and coaching staff to ensure they are working in a manner consistent with contemporary nursing practice.

My expert nursing advisor, Ms Spence, stated that as Nurse Leader, Ms E would have been responsible for the nursing care plans and directing the care of patients. She should have been supported in this role by the registered nurse in charge of each shift, but Ms E would be expected to check to see that the required tasks had been done.

Standard of care

When Mrs A was transferred to the rest home dementia unit on 22 August 2005 from the rest home/hospital, the intention was that her admission was short-term so that her recent deterioration of mood and suicidal ideation could be assessed for ongoing management. On admission, Mrs A was noted to have swelling to both legs. On 2 September 2005, the visiting doctor, Dr F, was asked to review Mrs A because of a wound to her left leg. He found no obvious infection, and staff were instructed to continue to dress the wound as required.

On 12 September, Mrs A was reported as having a "moist cough". Three days later the progress notes record that her cough was "productive". However, Mrs A was not referred to Dr F until a week later, on 19 September, when he assessed her cough and prescribed a cough mixture. Thereafter, Mrs A continued to cough intermittently over the next nine days. She was seen again by Dr F on 28 September. He checked her cardiac function and instructed staff to continue her charted treatment. The following morning, the health care assistants reported that Mrs A had been "wheezy" overnight. Mrs A's temperature was taken at 9.30am and noted to be 37.1°C. Staff were instructed to encourage her with fluids and provide analgesia. On 30 September, Dr F noted that Mrs A's respirations had increased to 26 to 28 breaths per minute, and he started her on antibiotics for a lower respiratory tract infection. Mrs A's daughter was informed that her mother was unwell. On 3 October, Dr F again reviewed Mrs A and ordered a chest X-ray.

The X-ray confirmed that Mrs A had bilateral basal bronchopneumonia with right lower lobe collapse. On 5 October, Dr F directed the nursing staff to continue with the antibiotics, but Mrs A was refusing food and fluids. On 7 October, Dr F noted that Mrs A's condition had deteriorated and that she had an infected ulcer on her right leg, and he arranged her admission to a public hospital for further assessment and treatment.

Ms Spence, my independent nurse expert, advised that it appears that Dr F initially thought Mrs A's chest was clear and that she was suffering a viral infection which did not require aggressive treatment. (This was supported by Dr F's response to the provisional opinion). However, as time progressed, and when Mrs A developed a moist cough, health care assistants recorded that they encouraged Mrs A to take sufficient fluids and made brief notes about her vital signs, but there is no evidence that

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the registered nursing staff followed through on these observations or on the initial assessment completed on admission.

Ms Spence stated that the registered nurses should have been more proactive in accurately assessing Mrs A's symptoms and reporting their observations to Dr F. The registered nurses should have followed up the healthcare assistants' consistent reports of Mrs A's troublesome cough with vital sign recordings and a care plan to assess and monitor her condition. The nurses should then have reported these observations to Dr F, in order to ensure timely assessment, testing and treatment. Ms Spence's views are shared by my independent general practice expert, Dr Tessa Turnbull, who commented that "moist", "productive" and "constant" cough are all symptoms of concern. Accordingly, these symptoms should have alerted nursing staff to the change in Mrs A's condition and the need to refer her promptly to a doctor. Instead, there was a one-week delay between 12 September 2005 when Mrs A was first noted to have a moist cough, and 19 September when she was reviewed by Dr F. In my view, the registered nurses missed the opportunity to involve Dr F at an early stage, and failed to ensure that Mrs A received medical care that was timely and appropriate to her needs.

Documentation
Registered nurse Ms H completed the initial assessment forms for Mrs A at her admission, which included a "Resident Assessment" form. Ms E advised that this form, which is to be completed within 24 hours of the patient's admission, acts as a "mini care plan" until a more comprehensive care plan is written. Any identified problems were to be discussed with her, as Nurse Leader.

The clinical records indicate that the health care assistants generally treated Mrs A kindly and thoughtfully and that they recorded their observations. However, there were only fifteen entries by registered nurses in Mrs A's clinical records during the 46 days she was at the rest home. Ms Spence advised that the registered nurses should have been making regular entries into the clinical record**.**

Ms Spence stated that the initial nursing assessment completed by Ms H provided good information on which to develop a nursing care plan. As well as her dementia, Mrs A had oedema (swelling) and skin damage to her legs. However, there were no nursing records relating to Mrs A's subsequent wound care, fluid intake/output, vital signs (such as temperature, blood pressure and weight), or nursing care plan. Such records would have provided guidelines for all staff caring for Mrs A. Ms Spence advised that all registered nurses must be able to complete the documentation required for safe patient care, and that this is a core course in all undergraduate nursing programmes. Good documentation is essential for patient safety. Ms Spence stated:

> "The overall documentation was poor and did not meet the current best practice. … I would view the overall standard of documentation as seriously deficient."

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Clinical oversight

The rest home provided clear, useful documentation guidelines for the registered nurses, and good policies and procedures to guide staff in the planning and documentation of Mrs A's care. However, the only documented information provided to staff was via the progress notes. As Ms Spence advised, this is not the purpose of the progress notes. The guidelines and policies provided should have been implemented by the registered nurses and monitored by the Nurse Leader, the Quality Improvement nurse, and/or the Site Manager.

Ms E had a detailed position description which outlined her leadership role and specified that she was responsible for working with the Group Quality and Clinical Managers and Site Manager to ensure the "quality and standards of clinical practice within the assigned area of the facility". She was also responsible for the clinical services budget, and had other managerial administrative duties as well. Ms Spence noted that this was an "extensive and challenging job description requiring significant knowledge and skill".

Ms Spence advised that the requirements of Ms E's role were better matched to a management role rather than that of a clinical leader. Ms Spence stated:

> "However, if [Ms E's] role was more clinical than indicated in her job description, I believe her clinical leadership was seriously deficient. … with little, and in some areas, no clear documentation to guide staff actions, I am seriously concerned about the care provided to [Mrs A]."

Conclusion

As nurse leader, Ms E was clearly responsible for clinical oversight to ensure quality services were provided to residents at the rest home. She was responsible for the implementation, monitoring and oversight of nursing procedures. The deficiencies in the documentation of Mrs A's care, and the lack of input into her care by the registered nurses, indicate that Ms E did not fulfil her responsibilities as Nurse Leader. Ms E was new to the nurse leader position at the rest home and she has said there was some resistance to the changes she was making and that she felt unsupported in dealing with that resistance. While I acknowledge these situations can be extremely difficult, I note she had had previous experience in a leadership role. Furthermore, she knew the documentation was not up to standard. Addressing this and providing direction to staff was part of her brief from management when she took on the nurse leader role. In my opinion, Ms E did not provide the clinical oversight required to ensure that Mrs A was provided with quality services. Therefore, by not providing services of an appropriate standard, Ms E breached Right 4(1) of the Code.

As a registered nurse, responsible for clinical oversight of the services provided to residents, Ms E was required to comply with the registered nurse competencies

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promulgated by the Nursing Council of New Zealand. The Nursing Council of New Zealand's "Competencies for registered nurse scope of practice" states that registered nurses should direct, monitor and evaluate the nursing care provided, and document and communicate relevant client information. In my opinion, Ms E did not comply with these competencies, and did not manage Mrs A's nursing care in a manner that was responsive to Mrs A's needs (Competency 4.0). By not providing adequate supervision, direction and support of the clinical team, Ms E did not ensure that Mrs A received timely, appropriate and safe services (as required by Standard 2.7 of the Health and Disability Sector Standards). Accordingly, in my opinion, Ms E breached Right 4(2) of the Code.

Opinion: Breach — The rest home/rest home company

The rest home had numerous systems/written policies and procedures in place to guide staff in a variety of care issues applicable to these events, such as management of wounds, procedures for care plans, and recording blood pressure, pulse, temperature and fluid balance. Registered nurses in New Zealand should be able to provide a reasonable standard of care to patients with Mrs A's needs. However, the registered nurses at the rest home in August and September 2005 failed to provide this standard of care to Mrs A.

The rest home also addressed quality issues by having in place an organisational quality framework. Although there appeared to be adequate systems in place in August/September 2005, lack of clear clinical leadership and mechanisms for monitoring the clinical policies and procedures resulted in Mrs A receiving services that were not of an adequate standard. Ms G, as Site Manager, should have had auditing systems in place to monitor the care of all the patients at the rest home, and thereby ensure that Mrs A received the appropriate standard of care.

One of the most striking features of this case is the "superficial" registered nurse input into Mrs A's care. Ms Spence was not able to comment on whether there had been adequate verbal direction given to the health care assistants by the registered nurses, but the lack of documentation, and lack of communication with allied health care providers and the family was, in Ms Spence's opinion, poor. There was no nursing care plan to provide direction on essential cares. The majority of the clinical entries and directions for care were made by the health care assistants in the progress notes. There was also a concerning gap in the clinical notes between 20 and 23 September, when Mrs A appeared to become increasingly unwell, yet no records were written.

Standard 2.7 of the New Zealand Health and Disability Sector Standards states that organisations must ensure that consumers receive safe, timely and appropriate services from suitably skilled service providers. In my view, by failing to have appropriate clinical monitoring and supervision of the quality management system, the rest home

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did not comply with this standard. I agree with Ms Spence's advice that this should be viewed with serious disapproval. Accordingly, in my opinion, the rest home did not provide services that comply with the relevant standards, and thus breached Right 4(2) of the Code.

Adverse comment — Dr F

Dr F first saw Mrs A two days after she was admitted to the rest home. At that time, he evaluated her prescribed medications and noted her medical conditions. He instructed the nursing staff to organise blood tests to check her heart medication levels and noted, when the results of the blood tests were reported to him five days later, that Mrs A was anaemic.

Dr F reviewed Mrs A four weeks later on 19 September, when nursing staff reported to him that she had been coughing for two days. As commented above, nursing staff should have informed Dr F sooner of Mrs A's cough to enable her to be seen more promptly by him. However, when Dr F examined Mrs A a week after her moist cough was first noted, he found her chest clear, and prescribed Brondecon elixir, which is a medication for acute and chronic bronchitis.

Nine days later, on Wednesday 28 September, Dr F saw Mrs A again. During this visit, Dr F again noted that, despite a persistent cough, Mrs A's chest was clear. He focused on excluding a cardiac basis for Mrs A's symptoms by ordering a blood test to test her heart function. He has said that Mrs A was not markedly unwell at this time. Two days later, on Friday 30 September, Dr F reviewed Mrs A again, and noted that she had crepitations on the right base of her lung. Based on his findings and the results of her blood test on 28 September, Dr F diagnosed Mrs A with myocardial ischaemia (heart damage) and pneumonia — a lower respiratory tract infection. Given the latter, Dr Turnbull has advised that Dr F should have organised a chest X-ray during this consultation. Instead, Dr F prescribed an antibiotic — doxycycline 100 mg twice daily for seven days, and instructed nursing staff that Mrs A was to be reviewed if she worsened over the weekend. I note Dr Turnbull's advice that this was a critical juncture in managing Mrs A's illness, and in my view, Dr F and nursing staff should have consulted with Mrs A's family about her management options and discussed referral to a public hospital. Their failure to do so prevented Mrs A's family from participating actively in her care and Dr F accepts that this was an oversight on his part.

Dr Turnbull noted that there was a period of nine days between Dr F's reviews of Mrs A on 19 and 28 September when her cough was not resolving and she was

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becoming increasingly confused. This was a long period given Mrs A's age and ongoing symptoms, and I agree with Dr Turnbull that an earlier review would have been beneficial and could have resulted in more timely investigation and intervention. However, I accept that Dr F was very reliant on the nursing staff to advise him of Mrs A's condition and her need to be seen. As previously discussed, the registered nurses' input into Mrs A's care was superficial, and there was no follow-through on the health care assistants' reports about Mrs A's deteriorating condition. It appears that Dr F did not review the integrated clinical records where it was documented that Mrs A's condition was not improving, but given that the registered nurse assumes overall responsibility for the health and well-being of residents in a rest home environment, I accept that it would not be reasonable to expect Dr F to read the health care assistants' notes.

The integrated clinical records do not mention that Mrs A's vital signs were being routinely monitored, and there is no evidence to suggest that Dr F directed or advised nursing staff to instigate vital sign recordings. In my view, it would have been prudent for him to have guided nursing staff in this respect, given Mrs A's ongoing cough and deteriorating health. This was particularly important when, on 3 October, Dr F found that Mrs A's temperature was elevated and she had signs of a chest infection. As a result of his review on 3 October, Dr F ordered a portable chest X-ray and instructed the nursing staff to continue the doxycycline and to start her on an additional antibiotic, Ciprofloxin. The results of the X-ray, faxed to Dr F later that day, showed that Mrs A had bronchopneumonia and a collapsed lower lobe in her right lung. I note that there was a four-day gap between Dr F's earlier diagnosis of pneumonia on 30 September and 3 October when his findings were confirmed by the results of the chest X-ray.

The Commissioner's in-house clinical advisor, Dr Stuart Tiller, initially queried Dr F's prescription of doxycycline to Mrs A in view of her renal impairment, and Ciprofloxin, stating that this was inappropriate as it is a "specialist only antibiotic" and should be reserved for specific serious infections and used with specialist endorsement. However, Dr Turnbull advised that Dr F's choice of doxycycline for Mrs A on 30 September was reasonable given that she had an intolerance/allergy to a number of medications, including penicillin. Dr Turnbull also considered that Dr F's choice of Ciprofloxin as the broad spectrum second line antibiotic was reasonable.

The Medical Council of New Zealand's *Good medical practice — A guide for doctors* states that good clinical care must include an adequate assessment of the patient's condition and taking suitable and prompt action when necessary. Dr Turnbull advised that Mrs A could have been admitted to a public hospital on 3 October, given the evidence of bronchopneumonia, especially in the presence of myocardial ischaemia. As discussed above, the decision to manage pneumonia in the rest home/hospital situation or a public hospital is not always straightforward because there are a number of factors to be taken into account before transferring the elderly patient. If Mrs A's family had been involved in the decision, they would probably have supported an earlier transfer. However, Dr Turnbull advised that there is differing medical opinion on the transfer of

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sick elderly patients from a rest home to a public hospital. Some doctors would recommend an early admission whereas others would support the patient being managed in the aged care facility. Dr F has indicated that in Mrs A's case he felt it was in her best interests to be medically managed in the rest home rather than to have repeated hospital admissions

Dr Turnbull commented on the "longish gap" between Dr F's reviews of Mrs A on 19 and 28 September, and advised that her deteriorating condition could have been managed better (for the reasons discussed above). However, she advised that there is no evidence of medical mismanagement on Dr F's part and he provided Mrs A with services of an appropriate standard. In addition, although Dr F's record-keeping was brief, Dr Turnbull commented that it was adequate, and not dissimilar to that of his peers.

In light of Dr Turnbull's advice, I am of the opinion that Dr F did not breach the Code of Rights. However, I am concerned by the apparent nine-day gap when Mrs A was not reviewed. Dr F has said Mrs A was clinically stable and there were no grounds to treat her differently during this period. However, given Mrs A's age and symptoms, I believe Dr F should have been more proactive, at the very least about arranging an earlier review following his visit on 19 September, and instructing the nurses to update him on any failure by Mrs A to improve, or any further deterioration in her health. I am left with a sense that Dr F's care could have been better, and will draw this matter to the attention of the Medical Council of New Zealand. I also note his slowness to respond to the complaint and investigation. Although Dr F explained that it took time to locate clinical records, there are processes for requesting an extension of time when there are good reasons for delays such as this. Simply remaining silent is an unacceptable response to a complaint, and I will remind Dr F that he is required to respond to complaints in a timely manner.

Other comment

Mrs B raised other concerns about the service provided to her mother by the rest home. Mrs B raised the issues of how management addressed her complaints about a resident entering her mother's room, taking her property and assaulting her, and about the provision of adequate food and fluids and medication administration. Ms Spence stated that Mrs B's complaints were justified and should have been acted upon at the time they were made. Although Ms G advised on 1 December 2005 that she had responded to those concerns and that the rest home systems and processes had been reviewed in light of Mrs B's concerns, there remains the issue of communication. I agree with Ms Spence that most of these matters could have been resolved with good communication, proactive nursing and good supervision and direction of staff.

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Furthermore, I note that Mrs A's family were not informed of her ill health until 1 October and yet it was clear her condition was deteriorating some days earlier. This is unacceptable and I will recommend that the rest home reviews its policies and practice in this regard.

Ms Spence registered her concern that the rest home was able to achieve certification against the Health and Disability Standards, given the standard of the documentation she reviewed when providing her advice on this case. Accordingly, I will recommend that the relevant District Health Board and the Ministry of Health consider a further review of the services provided by the rest home in light of Ms Spence's comments.

Actions taken

Ms E has provided a letter of apology to Mrs A's family.

Ms G (for the rest home/rest home company) provided a letter of apology for forwarding to Mrs A's family. Ms G has also outlined the changes made to systems and policies at the rest home to improve the service provided to residents at the rest home, and to ensure that what happened to Mrs A will not recur.

Recommendation

I recommend that Dr F:

- review his practice in light of this report.
- Apologise to Mrs A's family for his oversight in not talking with them about her management between 29 September and 7 October 2005.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Medical Council of New Zealand, HealthCERT, and the District Health Board. The Ministry of Health will be asked to consider an audit of the rest home's polices and procedures.
- A copy of this report, with details identifying the parties removed, will be sent to HealthCare Providers New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix 1 – Independent general practice advice

The following independent expert advice was obtained from general practitioner Dr Tessa Turnbull:

Initial advice

"**Purpose**

To provide independent expert advice about whether [Dr F] provided an appropriate standard of care to [Mrs A].

…[1]

Complaint

The appropriateness of the care provided to [Mrs A] by general practitioner, [Dr F] between 16 September and 7 October 2005.

Supporting Information

- Letter of complaint to the Commissioner from [Mrs B], dated 28 October 2005, marked with an 'A' (Pages 1 & 2)
- Letter to the Commissioner from the rest home Site Manager, [Ms G] (with attached nursing notes), dated 1 December 2005, marked with a 'B'. (Pages 3 to 18)
- *NB: Pages 19 & 20 marked in error*
- Letter to the Commissioner from [Ms G] (with attached clinical records), dated 12 January 2006, marked with a 'C'. (Pages 21 to 110)
- Letter to the Commissioner from [Ms G], dated 17 February 2006, marked with a 'D'. (Pages 111 to 116)
- *NB: Document 'E' relates to nursing process only*
- Letter to the Commissioner from general practitioner [Dr F] (with accompanying documents), dated 22 April 2006, marked with an 'F'. (Pages 153 to 156)
- Summary of the facts.

Expert Advice Required

To advise the Commissioner whether in your opinion [Dr F] provided [Mrs A] with services of an appropriate standard:

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[1] For the purpose of brevity the background facts have been deleted from Dr Turnbull's report.

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In particular:

- Was [Dr F's] choice and dosage of the antibiotic, doxycycline 100mg twice daily for seven days, for [Mrs A] on 30 September 2005 appropriate?
- [Mrs A] was noted to be allergic or intolerant to the antibiotics penicillin, roxithromycin and cotrimoxazole. The recorded penicillin allergy is vomiting to Augmentin and the nature of the intolerance to the other two is not recorded.
- [Mrs A] was a frail 85 year woman with multiple health problems. This included a recent admission to [a public hospital] for a heart attack on top of background problems of ischaemic and peripheral vascular disease, hypertension, atrial fibrillation, previous minor and a more serious stroke in 2001, mild renal impairment, acid reflux and chronic pain from a frozen left shoulder. In the background history, a right iliac fossa mass had been seen on ultrasound examination but further investigation was put on hold. In addition, there was a history of confusion and agitation on top of mild dementia and reading the clinical notes it seems these symptoms became worse in [the rest home] as [Mrs A's] bronchopneumonia developed.
- In deciding to prescribe doxycycline, [Dr F] no doubt considered the medical history and the history of drug allergy/intolerance. On odds, doxycycline was a reasonable choice. He may have considered and then dismissed erythromycin or bypassing the penicillin history as this was previously noted to be 'vomiting' with Augmentin rather than a true drug allergy.

Background

On 19/7/05, [Mrs A] had a comprehensive medical assessment undertaken by [a doctor] from [a mental health service] in [a city]. Together with a discharge summary from [a public hospital] where she was admitted between 28/6/05 and 1/7/05, an assessment undertaken by [a geriatrician] on 4/8/05 for private hospital placement and the assessment undertaken at the rest home on 22/8/05 a picture of [Mrs A's] health status in July and August 05 is evident. This was of a frail 85 year woman with multiple health problems.

The reason for the admission to hospital was a heart attack on top of background problems of ischaemic and peripheral vascular disease, hypertension, atrial fibrillation, previous minor and a more serious stroke in 2001, mild renal impairment, acid reflux and chronic pain from a frozen left shoulder In the background history, a right iliac fossa mass had been seen on ultrasound examination but further investigation was put on hold. In addition, there had been a history of 4 weeks of confusion and agitation on top of mild dementia.

[Mrs A] was discharged from hospital back to [the rest home/hospital], on 14 different medications to cover her various medical problems. This included 12.5mg quetiapine, .25mg Halcion and 10mg amitriptyline at night.

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She was noted to be allergic or intolerant to penicillin, roxithromycin, cotrimoxazole, morphine, anti-inflammatories, bendrofluazide and captopril.

On 22 August 2005, she transferred from [the rest home/hospital] to the dementia unit of the rest home for a short stay for behaviour management and dementia assessment. The initial assessment at [the rest home] on admission indicated that [Mrs A] was liable to wander into other residents rooms, her memory was generally poor but she could [be] very lucid at times, she had a high risk of falls but nevertheless could understand and speak clearly and had control of her bladder and bowels. [Dr F] undertook a medical assessment on that date and both his notes and nursing notes showed swelling of both legs.

On 12 September 2005, [Mrs A] was noted to have a 'moist cough' and on 15/9/05, 'quite a productive cough.' On 16/9/05 she was described as 'constantly coughing' and this cough was again noted on 17/9, 18/9 and 19/9.

On 19 September, [Mrs A] was seen by [Dr F], who found her chest to be clear and prescribed Brondecon elixir [medication for acute and chronic bronchitis].

[Mrs A] continued to cough intermittently over the next nine days. She was reviewed by [Dr F] on 28 September. He noted that her chest was clear, and her heart rate irregular. [Dr F] ordered blood tests to check her troponin levels, full blood count, white cell count and renal function. [Dr F] was informed that evening that [Mrs A's] troponin level was 0.15. He instructed nursing staff to continue the charted treatment.

The following day [Mrs A] was noted to be 'wheezy in the night.' She appeared to be chesty and was complaining of burning in her throat. Her temperature, taken at 9.30am on 29 September, was recorded as 37.1°C. The nursing plan was to encourage [Mrs A] with fluids, provide regular analgesia and arrange for her to be seen by [Dr F] the following day.

On 30 September, [Dr F] reviewed [Mrs A] and noted, 'chest creps at right base' and that [Mrs A] had a respiration rate of 26 to 28. He also noted her raised troponin level and white cell count and concluded that [Mrs A] was suffering from myocardial ischaemia and a lower respiratory tract infection. He prescribed doxycycline 100mg twice daily for seven days and instructed the nursing staff that she was to be 'reviewed if she worsened' over the weekend.

[Mrs A] commenced on doxycycline on 1 October. [Mrs A's] daughter was informed about her condition.

The following day [Mrs A] was noted to be 'unwell' and reluctant to feed herself.

[Mrs A] was seen again by [Dr F] on 3 October. He noted her temperature to be

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37.2°C, found that she had decreased air entry at the base of her left lung, and ordered a portable chest X-ray. [Dr F] instructed the nursing staff to continue with the doxycycline and added Ciprofloxin 500mg twice daily for seven days. The chest x-ray was taken at 1pm. The result, faxed to [Dr F], reported bilateral basal bronchopneumonia with right lower lobe collapse.

[Dr F] reviewed [Mrs A] on 5 October, noted that she was improving and instructed the nursing staff to complete her course of antibiotics. [Mrs A] was refusing food and fluids.

The nursing staff recorded that they encouraged [Mrs A] with fluids for the next 24 hours.

On 7 October, [Dr F] reassessed [Mrs A]. He noted that she had deteriorated in the previous 24 hours with increased cough and decreased fluid intake and [had] an infected ulcer on her right leg. He arranged to admit her to [a public hospital].

Was the addition of the antibiotic Ciprofloxin 500mg twice daily for seven days on 3 October 2005 appropriate?

Dr F was faced with the need to add a second line antibiotic with a broad spectrum and Ciprofloxin was a reasonable choice faced with the above.

If not, what treatment would have been appropriate?

Admission to [the public hospital] does not seem to have been considered or may have been considered and decided against.

Was [Dr F's] management of [Mrs A's] deteriorating condition reasonable?

[Dr F] examined [Mrs A] on many occasions during her admission and associated illness and seems to have had a good grasp of her many problems, ie, on 19 September, he found her chest to be clear and prescribed brondecon elixir.

She was reviewed again by [Dr F] on 28 September. He [noted] again that her chest was clear and he ordered blood tests to check her troponin levels, full blood count, white cell count and renal function. This would indicate some concern at the clinical picture presented.

On 30 September, [Dr F] reviewed [Mrs A] and concluded that she was suffering from myocardial ischaemia and a lower respiratory tract infection on the basis of his examination and the laboratory results. At this stage he prescribed doxycycline 100mg twice daily for seven days.

[Mrs A] was seen again by [Dr F] on 3 October. He noted her temperature to be 37.2°C, found that she had decreased air entry at the base of her left lung indicating pneumonia, and he ordered a portable chest X-ray. He was made aware that the

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chest X-ray showed bilateral basal bronchopneumonia with right lower lobe collapse.

[Dr F] decided to manage the pneumonia by adding Ciprofloxin 500mg twice daily for seven days to [Mrs A's] drug regimen.

[Dr F] reviewed [Mrs A] on 5 October, and thought that she was improving.

On 7 October, [Dr F] reassessed [Mrs A]. He noted that she had deteriorated in the previous 24 hours with increased cough and decreased fluid intake and [had] an infected ulcer on her right leg. He arranged to admit her to [a public hospital].

If it was not, what else should he have done?

In hindsight [Mrs A] could have been managed better i.e. the cough was a new symptom and was left some days before it was brought to [Dr F's] attention. There was a longish gap between reviews on 19/9 and 28/9. During the illness [Mrs A's] cough was described as 'moist', 'productive' and 'constant', all symptoms of concern. Fever, or the lack of it, is not a helpful sign in the frail elderly. In addition, [Mrs A] showed evidence of increasing confusion.

Perhaps when the chest X-ray showed very convincing evidence of bronchopneumonia on 3/10, [Mrs A] could have been admitted to [a public hospital] at that point especially as there was evidence of concurrent myocardial ischaemia.

The decision to manage pneumonia in a rest home or associated hospital or admit to a public hospital is not always straightforward. It takes into account such factors as preceding history, family and personal wishes and intolerance or otherwise to medication.

I suspect that [Mrs A's] family would have supported an earlier admission to [hospital] had they been consulted about this particular issue.

Some of [Dr F's] peers would probably take this view as well whereas others would have taken [Dr F's] approach to manage the pneumonia in the rest home/hospital setting.

Considering all these factors, on the evidence, I believe that [Dr F] provided [Mrs A] with services of an appropriate standard."

Additional advice

On 17 October 2006, Dr Turnbull was contacted for clarification on some matters raised by my independent nursing advisor, Lesley Spence. On 29 October 2006, Dr Turnbull provided the following additional advice:

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"Thanks for forwarding me Ms Spence's concerns about [Dr F's] management of [Mrs A's] bronchopneumonia and in particular his apparent slow intervention.

Ms Spence speculated as to whether this may have been due to poor reporting to [Dr F] by nursing staff regarding their concerns or whether he thought the cough was viral in origin and therefore antibiotics likely to cause more harm than good.

She felt that [Dr F] should have seen the consistent recording of [Mrs A's] troublesome cough by health care assistants.

I will repeat the statement that I made in my report:

The decision to manage pneumonia in a rest home or associated hospital or admit to a public hospital is not always straightforward. It takes into account such factors as preceding history, family and personal wishes and intolerance or otherwise to medication.

I suspect that [Mrs A's] family would have supported an earlier admission to [a public hospital] had they been consulted about this particular issue.

Some of [Dr F's] peers would probably take this view as well whereas others would have taken [Dr F's] approach to manage the pneumonia in the rest home/hospital setting.

My judgement that [Dr F's] management was adequate was based on the following mitigating factors:

1. [Dr F] knew that [Mrs A] was frail with both multiple background health problems and drug sensitivities.

2. He was likely to have assumed that [Mrs A's] cough was viral on 15/9 when he examined her by his choice of cough mixture.

3. Rightly or wrongly, [Dr F] was focused on excluding a cardiac basis to [Mrs A's] symptoms when he saw her on 28/9 as evident by his choice of tests and management. He then switched his focus to antibiotic management with all its difficult choices on 30/9 although the antibiotic was not started until the following day. The illness then evolved in spite of this management and the addition of a second line antibiotic.

Looking back, the illness could have been handled better as I previously mentioned:

In hindsight [Mrs A] could have been managed better ie the cough was a new symptom and was left some days before it was bought to [Dr F's] attention. There was a longish gap between reviews on 19/9 and 28/9. During the illness [Mrs A's] cough was described as 'moist', 'productive' and 'constant', all symptoms of

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concern. Fever, or the lack of it, it not a helpful sign in the frail elderly. In addition, [Mrs A] showed evidence of increasing confusion.

Perhaps when the chest X-ray showed very convincing evidence of bronchopneumonia on 3/10, [Mrs A] could have been admitted to [hospital] at that point especially as there was evidence of concurrent myocardial ischaemia.

I do not think it reasonable for [Dr F] to have read the health care assistants notes. Doctors and nurses do support each others practice. In this instance it was the registered nurses job to give [Dr F] a clear history as [Mrs A] could not do this herself."

Further advice
Dr Turnbull was contacted for further clarification. On 1 and 10 December 2006, Dr Turnbull advised the following:

"1. What actions should have been taken to improve the care provided to [Mrs A], particularly between the period 19/9 and 28/9?

Between the 12th and the 19th September, [Mrs A] appeared unwell with daily recordings of a significant cough ie the notes record a 'moist cough', 'quite a productive cough' and 'constantly coughing'.

This symptom should act as an alert to the nursing staff that there was a change in [Mrs A] health status and prompt a medical examination.

On 19th September, [Mrs A] was reviewed by [Dr F]. He found her chest to be clear and was satisfied that there was no localized infection. He prescribed brondecon elixir for the cough.

[Dr F] may have missed an opportunity to be more proactive in [Mrs A's] management at this point. A 'moist', 'productive' and 'constant' cough are symptoms of concern. Fever, or the lack of it, is not a helpful sign in the frail elderly. [Mrs A] showed evidence of increasing confusion.

[Mrs A] continued to cough intermittently over the next nine days. This is a long period in view of her symptoms and an earlier review might have prompted earlier investigation.

[Dr F] reviewed [Mrs A] on 28/9 and noted that her chest was clear and her heart rate irregular. He ordered blood tests to check her troponin levels to check for cardiac damage, a full blood count, white cell count and renal function. His focus was on the cardiac side in view of her previous history of ischaemic heart disease.

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[Dr F] was informed that evening that [Mrs A's] troponin level was 0.15, ie, there was an indication of cardiac damage. He instructed the nursing staff to continue the charted treatment.

Consultation with the family at this point would have been helpful. It would have been an opportunity to review management options ie. to continue care and comfort in the existing rest home environment or opt for more active hospital management.

The decision to manage myocardial infarction or other cardiac conditions and/or pneumonia in a rest home or associated hospital or admit to a public hospital is not straightforward. It takes into account such factors as preceding history, family and personal wishes and intolerance or otherwise to medication. Consultation with [Mrs A's] family might have supported an earlier admission to [hospital]. At least they would have been active participants in the decision making.

The following day, [Mrs A] was noted to be 'wheezy in the night.' She appeared to be chesty and was complaining of burning in her throat. Her temperature, taken at 9.30am on 29 September, was recorded as 37.1°C. The nursing plan was to encourage [Mrs A] with fluids, provide regular analgesia and arrange for her to be seen by [Dr F] the following day.

On 30 September, [Dr F] reviewed [Mrs A] and noted, 'chest creps at right base' and that [Mrs A] had a raised respiratory rate of 26 to 28. He also noted her raised troponin level and white cell count and concluded that [Mrs A] was suffering from myocardial ischaemia and a lower respiratory tract infection. He prescribed doxycycline 100mg twice daily for seven days and instructed the nursing staff that she was to be 'reviewed if she worsened' over the weekend.

This was the critical point in the illness and the point that a hospital admission would have been appropriate unless the family opted for ongoing rest home management.

My judgment that [Dr F's] management was adequate was based on the following mitigating factors:[2]

…
However, [Dr F] could be criticised for:

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[2]The mitigating factors have been omitted as they are a repeat of the additional advice Dr Turnbull provided in October 2006.

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(1) [Mrs A's] family were 'informed' of her condition but not consulted on their views regarding her medical management at critical points in her illness.

(2) Insufficient regard was taken of the cough which was persistent and moist.

(3) [Dr F] was aware that [Mrs A] had pneumonia ie 'creps R base' on 30/9 but did not organize a CXR until 3/10.

(4) There should be specific direction to record vital signs in the face of deteriorating health status.

1. Comment on the adequacy of the advice/direction that [Dr F] provided to nursing staff at the rest home. In particular, should [Dr F] have directed nursing staff to record [Mrs A's] vital signs when there were indications that she had a chest infection?

It is clear that these important recordings of vital signs were not asked for or recorded automatically. [Dr F] was concerned about the seriousness of [Mrs A] condition as both his notes, and the nursing staff's, indicated that he was to be informed if [Mrs A's] condition deteriorated over the weekend.

There is no evidence that [Dr F] provided adequate advice or direction to the nursing staff at [the rest home] and he should have done this in the face of [Mrs A's] deteriorating health status.[3]

2. Comment on whether [Dr F's] documentation was of an adequate standard.

It is brief but would not be dissimilar to many of his colleagues.[4]

4. Any other aspects of [Dr F's] care that you consider warrants additional comments.

[Dr F] reviewed [Mrs A] regularly. He could be criticized for not involving [Mrs A's] family in the active management of her deteriorating condition and for not admitting her earlier for more aggressive treatment of her pneumonia. However, there is no evidence of medical mismanagement."

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[3] As clarified by Dr Turnbull on 14 December 2006.
[4] On 11 December 2006, Dr Turnbull clarified that [Dr F's] record-keeping was brief but adequate.

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Appendix 2 — Independent nursing advice

The following expert advice was obtained from registered nurse Ms Lesley Spence:

"My name is Lesley Wynne Spence and I have been asked to provide a nursing opinion to the Commissioner on case number 05/15501.

I have read carefully the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Qualifications and Experience

I am a registered general and obstetric nurse (1963) and hold an Advanced Diploma of Nursing (1981, Distinction) specializing in medical nursing.

Following graduation I worked in an acute medical surgical hospital becoming a staff nurse in a medical ward and prior to being promoted to a nurse tutor position was Sister-in-Charge of Christchurch Hospital on night duty (600 patients).

I taught General Nursing for 3 years (1966–1969) and then had a period raising a family during which time I worked part-time in a hospital for the Aged.

In 1975, I was invited to teach in then quite new Comprehensive Nursing programme at Christchurch Polytechnic where I was employed for 18 years.

During these years, I taught most comprehensive nursing courses but in the latter 5 years, I had the responsibility for Post graduate short courses which included courses in Gerontology (care of the Aged). It was the relevance of this knowledge that in 1996 led me to accept the offer of a nurse manager's position in a large modern rest home caring for approximately 80 seniors. There I began to apply my learning to practice — I found it rewarding to be able to teach Registered Nurses and caregiving staff and see the benefits of their knowledge conveyed to the residents. I also developed skills in management which assisted in meeting the challenges of running a rest home.

From this rest home I was invited by new employers to develop a 60 bed rest home, Middlepark Senior Care Centre, from the building plans up — this gave me the opportunity to modify design, plan appropriate furniture, furnishing and equipment, write the policies and procedures, employ, orientate and educate the staff and develop trusting relationships with the residents.

While challenging, this project was enormously satisfying as I was able to implement the nursing philosophies I believed in.

Since then a further 2 rest homes, The Oaks Senior Care Centre (150 residents) and Palm Grove Senior Care Centre (118 residents) have been built to include long-term hospitals. Palm Grove was opened in December 2003.

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My role has changed to Principal Nurse Manager with oversight of the 3 centres.

I am a member of:

- New Zealand Nurses Organisation
- New Zealand Association of Gerontology
- Healthcare Providers NZ (& Canterbury Branch committee member)
- New Zealand Retirement Villages Association

I have recently facilitated a group of nurse managers to meet regularly in order to seek solutions to the serious shortage of registered nurses and caregivers in Canterbury.

I act as an advisor for;

- Christchurch Polytechnic Institute of Technology Post Graduate Courses for Nurses
- Health & Disability Commissioner
- Health Education Trust with input into the Aged Care Education courses for caregivers

I regularly attend conferences and courses associated with the care of seniors in rest home and continuing care facilities.

Palm Grove Senior Care Centre has been chosen by the Ministry of Health to provide education for Bachelor of Nursing students, Nurse Assistants and the competency Assessment programme for Registered Nurses who wish to return to the workforce.

I have been asked to report as to whether registered nurse [Ms E] and the rest home promoted an appropriate standard of care to [Mrs A].

Background

On 22nd August 2005, [Mrs A] transferred from [a rest home/hospital] to the dementia unit of the rest home for short stay for behaviour management and dementia assessment.

On 15th September 2005, [Mrs A] developed a 'productive cough'. For the next three days she was given cough mixture with little effect.

On 19th September, [Mrs A] was seen by general practitioner, [Dr F], who noted that she had been coughing over the weekend but gave no orders for treatment or monitoring.

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[Mrs A] continued to cough intermittently over the next nine days. She was reviewed by [Dr F] on 28 September. He noted that her chest was clear but her heart rate irregular. [Dr F] ordered a blood test to check her troponin levels. [Dr F] was informed that evening that [Mrs A's] troponin level was 0.15. He instructed nursing staff to continue the charted treatment.

The following day [Mrs A] was noted to be 'wheezy in the night'. She appeared to be chesty and was complaining of burning in her throat. Her temperature, taken at 9.30am [on] 29 September, was recorded as 37.1°C. The nursing plan was to encourage [Mrs A] with fluids, provide regular analgesia and arrange for her to be seen by [Dr F] the following day.

On 30 September, [Dr F] reviewed [Mrs A] and noted, 'chest creps at right base' and that [Mrs A] had a respiration rate of 26 to 28. He prescribed doxycycline 100mg twice daily for seven days and instructed staff that she was to be 'reviewed if she worsened' over the weekend.

[Mrs A] commenced the doxycycline at 9.00 a.m. On 1st October that evening and the antibiotics were given 2 x daily until 6th October when the course was completed. On 1st October, [Mrs A's] daughter was informed about her condition.

The following day she was noted to be 'unwell' and reluctant to feed herself. There is no record of any vital recordings being ordered to be taken.

[Mrs A] was seen again by [Dr F] on 3rd October. He noted her temperature to be 37.2°C, found that she had decreased air entry at the base of her left lung, and ordered a portable chest X-ray. [Dr F] instructed the nursing staff to continue with the doxycycline and add Ciprofloxin 500mg twice daily for seven days. The chest x-ray, 3rd October, was taken at 1 p.m. The result faxed to [Dr F], reported bilateral basal bronchopneumonia with right lower lobe collapse.

[Dr F] reviewed [Mrs A] on 5th October, noted that she was improving and instructed the nursing staff to complete her course of antibiotics. [Mrs A] was refusing food and fluids.

The nursing staff recorded that they encouraged [Mrs A] with fluids for the next twenty-four hours.

On 7 October, [Dr F] reassessed [Mrs A]. He noted that she had deteriorated in the previous 24 hours and arranged to admit her to [a public hospital].

[Mrs A] was discharged from [hospital] to [the rest home/hospital] on 12th October 2005 as she had been reassessed as requiring hospital level care at that time.

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Complaint:

- The appropriateness of the care provided to [Mrs A] by the rest home between 16 September 2005 and 7 October 2005.
- The adequacy and appropriateness of the care provided to [Mrs A] by Nurse Leader, [Ms E] between 16 September and 7 October 2005.

Supporting Information

- Letter of complaint to the Commissioner from [Mrs B], dated 28 October 2005, marked with an 'A'. (pages 1 & 2)
- Letter to the Commissioner from the rest home Site Manager, [Ms G] (with attached nursing notes), dated 1 December 2005, marked with a 'B'. (pages 3 to 18)
- Letter to Commissioner from [Ms G] (with attached clinical records), dated 12 January 2006, marked with a 'C'. (pages 21 to 110)
- Letter to the Commissioner from [Ms G] (with attached job descriptions and policies), dated17 May 2006, marked with an 'E' (pages 117 to 152)
- Letter to the Commissioner from the rest home Nurse Leader, [Ms E], dated 13 June 2006, marked with a 'G' (pages 158 to 160)
- Position descriptions of Site Manager & Nurse Leader
- [The rest home] Policies & Procedures relating to clinical records, care plans and documentation guidelines.

EXPERT ADVICE REQUIRED — 05HDC15501

Re: [Ms E]

Care provided for [Mrs A] when she had a productive cough

1. During this period according to mostly *health care assistant* notes she was toileted regularly, occasionally encouraged with fluids and had dressings done to her legs.

   From 12 September when [Mrs A's] coughing was first reported to 30 September when the Doctor charted antibiotics (18 days), there were only 3 entries in the clinical notes made by registered nurses. The entries made included the following nursing directions:

   19/09/2005 — cough mixture and Throaties available for cough
   28/09/2005 — A troponin result reported and to continue same treatment
   29/09/05 — Vital signs were taken and advice given to encourage fluids and to give regular analgesia

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As mentioned earlier, cough mixture was given. Initially, pholcodine from 17 September to 19 September and then, the prescribed Brondecon from 19 September was given fairly regularly.

Analgesia (Panadol/paracetamol) was given twice daily from 4 September to 7 October.

The treatment of the cough was probably inadequate.

Initially the Doctor thought the chest was clear even though staff were consistently reporting a moist cough. It is probable the Doctor considered that the cough was viral and inappropriate to treat it at that time. As time progressed, the registered nurse could have been more proactive in reporting more accurately [Mrs A] symptoms to him although as medical progress notes are recorded in the same clinical record as the nursing notes, the Doctor should have seen the consistent recording by healthcare assistants of [Mrs A's] troublesome moist cough. This would have allowed assessment, tests and treatment to be initiated earlier.

Overall, the medical care of [Mrs A's] cough was only fair and using the only documentation available to measure nursing performance it could only be described as fair also.

What should have been done?

Using the records provided (which do not take into account verbal direction) it has to be stated that there was insufficient documentation from the Registered Nurses on duty to guide the care being given to [Mrs A].

As stated earlier only 3 written entries during this period are by Registered Nurses are found in the clinical notes.

There is **no** nursing care plan which should have included nursing direction related to the following:

- a safe environment
- food and fluids
- personal hygiene
- grooming
- continence — bowel and bladder
- skin integrity
- freedom from pain
- anxiety and wandering
- memory — orientation
- respiration — where issued related to the cough would be addressed
- mobility

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- communication
- sleep and rest
- spirituality
- recreation and social enjoyment

Care provided could only have been considered superficial.

Clinical Record

The registered nurses should also have been making regular entries into the clinical record.

Clear useful documentation guidelines for Registered Nurses and clinical records policies have been provided at [the rest home] since at least February 2005 and these should have been implemented by the registered nurses and monitored by the Quality Improvement nurses and/or the site manager.

In the position descriptions provided for the site manager, principal responsibilities and associated duties:

5. Ensuring the implementation of all organisational policies related to clinical practices
   - ensuring clinical competence in conjunction with Group quality/clinical officer and nurse leaser.

The position description for the Nurse Leader Hospital/Dementia states:

2. Working with the Group Quality and Clinical Manager and the Site Manager to ensure the quality and standards of clinical practice within the assigned facility.
   - Implementation of all organisational policies and procedures related to clinical practice.

In the Assessment and Care Planning policy 'Outcome Criteria for Assessment & Care Planning:

5. *That each resident will have a resident-centered plan of care, developed by a Registered Nurse, within 3 weeks of admission, that incorporates input from the resident/family and is recorded in sufficient detail to address the resident's physical needs, level of independence, personal preferences, cultural and spiritual needs.*

7. *That each resident's long term plan will contain current, relevant information with amendments being made by designated personnel as*

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changes occur. Each plan will be evaluated at least every six months, incorporating decisions made during the Care Review Progress, to ensure relevance, accuracy and achievement of goals. Evidence will be available to demonstrate response to identified deficits.

The Clinical Records Policy states that the registered nurses will at all times be responsible for ensuring compliance of this policy.

Page 2. (Relevant information)

Nursing

- *Within 24 hours of admission, an initial assessment is documented from available information.*
- *Full review takes place within 4 weeks of admission, allowing for the resident to settle and acclimatize to the new environment. This includes an assessment by the Registered Nurse. The Registered Nurse and resident complete the full assessment and care plan. At this stage the resident/next of kin is able to state their needs, identify with the plan and hear what alternatives are realistically available. Where possible, the care plan is signed off by the resident, next of kin or EPOA holder at the time of drawing it up.*
- *Care given as per the care plan is evaluated regularly and the plan is adjusted as necessary and signed off by the RN. The frequency is according to the Ministry of Health contract, and also when the resident's change of health status necessitates review. Care workers and/or registered nurses routinely review care plans, with the resident where possible. Problems arising or special needs are assessed by the registered nurse.*
- *The care plan is updated at any time of special needs/crisis care and as part of the evaluation /reassessment process.*
- *Any person who provides care, documents that care in the clinical records.*

and from Page 7

- *There will be a minimum of one entry by the Registered Nurse:*
  - *— per 24 hours in the hospital — higher level of care*
  - *— per 24 hours in dementia care*
  - *— per week in the rest home — lower level of care*
  - *— entries are preferable rotating over the different shifts*

Health care assistants can make an objective entry per shift in resident notes.

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Clear Documentation Guidelines for Registered Nurses also provided:

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Please document the following in the resident's health record where they apply to the residents you are caring/supporting for —

- *Details of care given*
- *Significant changes in residents health status*
- *Assessment and Care Plan — updating any changes to residents health status*
- *Observations, eg, weight loss, BP, temperature*
- *Medication issues*
- *Procedures undertaken*
- *Resident/family education*
- *Fluid balance*
- *Treatments/consultations*
- *Family contact/communications*
- *Participation in programmes/activities*
- *Accurate objective description of resident behaviour when documenting non-compliance*
- *Specific objective information reported to doctor including date and time notified*
- *Referrals made to other disciplines*
- *Incident/Accident reporting*
- *Restraint Assessment*

Almost none of the required documentation as per policies was done.

Overall Standard of Documentation

The overall documentation was poor and did not meet current best practice, [the rest home company] policies and procedures or the Health and Disability Standards.

Except for the initial nursing assessment made by [Ms H] (RN) which provided good information on which to develop a nursing care plan, no supportive records were provided for:

- fluid intake and output
- wound care
- vital signs: temperature, blood pressure and weight
- physiotherapy
- occupational or diversional therapy
- the nursing care plan

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Medication Administration records appeared accurate. Clinical notes (progress notes) were written on most days but were written primarily by health care assistants in the afternoons and during the night. There were only 15 entries during the total period [Mrs A] was at [the rest home] made by registered nurses and there was a significant gap for 2 days when no reports were written at all.

I would view the overall standard of documentation as seriously deficient.

Responsibility for planning and overseeing care of [Mrs A]

The registered nurse in charge (nurse leader — hospital dementia) is normally responsible for writing and updating the nursing care plan and directing the care of patients. She should be supported in this role by the registered nurse in charge of each shift who adds direction to the care plan, records changes to the patients condition in the clinical notes (progress notes) and supervises the health care assistants.

The registered nurses on duty over the 24 hours would take responsibility for calling Doctors or other health professionals if a patient's condition deteriorated, implementing changes to care and advising the family.

What action would be expected of a registered nurse if a patient was causing concern?

Vital signs would be taken and a physical assessment made. If necessary the Doctor or allied health professional would be called.

Their advice would be implemented e.g. antibiotics ordered from pharmacy and administered or specimens sent to laboratory.

The patient would be made comfortable.

Nursing actions would be recorded on progress notes and further direction to staff given.

Care plans updated

Relevant staff advised both verbally and through the updated records of changes to care.

Family/significant other advised and noted.

[Ms E's] role

If on duty, to complete the above actions or to check when next on duty to see that they had been done and if not require the on duty staff at that time to do them.

She would also have a role in ensuring that suitable forms were available and staff were educated on how to complete them. NB: All registered nurses must be able to complete the documentation required for safe patient care. Documentation for

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patient safety and to comply with legislation is a core course in all undergraduate nursing programmes.

[Ms E's] (RN) standard of care

On reading [Ms E's] responses to the Health and Disability Commissioner Investigator it appears she was appointed to correct many deficiencies found at the rest home. As stated in her report, she had some concerns about this role and for this reason she accepted a trial employment period (August– September 2005). This was made a permanent position in October 2005.

She found staff resistant to change but with the support of the also new site manager she decided to persevere.

In her role as Nurse Leader, [Ms E] had a detailed position description which outlined her responsibilities as:

1. Leadership of the team supporting older people and their family/Whanau to achieve shared philosophy of care.
2. Working with the Group Quality and Clinical Manager and the Site Manager to ensure the quality and standards of clinical practice within the assigned area of the facility.
3. Ensuring that the site achieves organisational and national standards.
4. Effective and responsible management of the clinical services budget within the Area.
5. Effectively managing those who directly report to the Nurse Leader.
6. Ensuring compliance with Health and Safety legal requirements, company policies and procedures.
7. Carrying out other managerial administration duties.

This is an extensive and challenging job description requiring significant knowledge and leadership skill.

However, the requirements listed appear to be better matched to a management role not to that of a clinical leader which this report is investigating.

However if her role was more clinical than indicated in her job description I believe her clinical leadership was seriously deficient in relation to the —

a. Clinical progress notes

   There was very limited reporting from [Ms E] and other RNs in the clinical (progress) notes.

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In the 46 days the notes covered there were only 15 entries made by registered nurses. Most entries were made by health care assistants, some in the p.m.s and most nights. Many of these reports indicated careful observation of [Mrs A] and describe her behaviour and health needs well. There is however a concerning gap in the clinical notes between 20 September and 23 September when no records were written. This was during the period when [Mrs A] appeared to become increasingly unwell.

b. Nursing Care Plan

A useful initial nursing assessment was made but not followed up by the development of a nursing care plan. This would have provided the nursing guidelines for all staff caring for [Mrs A].

Good frameworks for writing nursing care plans were available (developed February 2005 but not used).

c. Wound Care Plan

None provided and was needed as [Mrs A] had significant problem with oedema and skin damage in her lower legs.

d. Vital Sign Recordings Form

None provided and only brief mention of vital signs made by health care assistants in the clinical records. I could find no record of even baseline recordings of temperature, pulse, respiration, blood pressure and weight being taken.

e. Fluid Balance Record

None provided and no evidence that this was measured. Health care assistants made note of fluids being encouraged but no quantities were mentioned.

f. Overall supervision and direction of staff

While there may have been significant and useful verbal direction of staff, it is not possible to assess this in this report. There may also have been good role modelling, however; with little, and in some areas, no clear documentation to guide staff actions I am seriously concerned about the care provided to [Mrs A].

I would see both [Ms E] and the Site Manager [Ms G] to be equally responsible for the insufficient documentation and subsequent less than satisfactory care provided to [Mrs A].

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The rest home

1. **Was the oversight of care between 12 September and 7 October 2005 deficient?**

While I cannot comment on the verbal direction given to the health care assistants which may have been useful, the lack of documentation with allied health care providers and the family was poor.

2. **Was there any aspect of the systems that were in place at [the rest home] village that contributed to the failure of nursing staff to appropriately monitor and document [Mrs A's] condition.**

   Good policies, procedures and forms were available for staff to use however; apart from an excellent initial assessment of [Mrs A], this information was not used to guide and document her nursing care.

   The only documented information provided for staff was via the clinical record (progress notes) and that is not their purpose.

   What the clinical notes do identify is that generally [Mrs A] was treated kindly and thoughtfully by the health care assistants who made observant comments about her behaviour and the care they gave her.

   The Registered Nurse input is superficial — only 15 entries in 46 days of [Mrs A] stay at the rest home (note — some signatures I was unable to decipher, nor did they indicate the writers status) so the recorded entries by R.N.s may be slightly different.

3. **Who has the responsibility in an organisation such as the [rest home/rest home company], to ensure that there are appropriate and effective systems in place to ensure that a reasonable standard of care is provided to their residents and patients?**

   Nurses registered in New Zealand should be able to provide a reasonable standard of care for a patient with needs such as [Mrs A]. She did not require highly specialised care, only those skills which could assist her with her confusion, anxiety, wound care and her cough.

   [Ms E] should have been able to supervise this care and her Site Manager [Ms G] should have had auditing systems (as required by the Health & Disability Sector Standards) in place to monitor the care of all residents and patients at the rest home thus ensuring that [Mrs A] received appropriate care and the requirement of certification were met.

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The rest home Standards of Care

I believe that the rest home did not provide an adequate standard of care to [Mrs A] and this should be viewed with serious disapproval.

Additional comment related to the care of [Ms E]

In regard to [Mrs B's] complaint:

- Communication with relatives appeared inadequate and the nurses' response to the family's request for help appeared poor (e.g. giving family cream to rub on [Mrs A's] sacrum).
- The family also felt that she was not eating and drinking well even though staff said she was. There were entries stating she was given food and fluids but no fluid balance record was kept even when she was very ill.
- The management of '[the patient]' who wandered into [Mrs A's] room also appeared inadequate and no relative should be asked to go into another resident's room to retrieve belongings.

I believe many of the family's complaints were justified and should have been acted upon at the time they were made. Most issues could have been solved with warm communication, proactive nursing and good supervision and direction of staff.

While it may be inappropriate for me as a nurse to comment on the Doctor's care of [Mrs A's] chest infection, his intervention did appear to be slow — this may have been due to poor reporting from the nurses or because he believed the cough to be viral in origin — of concern was the fact that staff from 12 September 2005 were reporting a moist cough, cough mixture was charted on 16 September and on 19 September. Further medical care and antibiotics were not provided until 30 September and changed on 3 October when a chest x-ray was also ordered.

By this time [Mrs A] was quite ill, the Doctor describing her as looking weak. Although the chest x-ray showed some bronchopneumonia she did improve a little but on the 11 October 2006 when her chest was still moist and she had developed an infected right calf, the Doctor decided to admit her to acute care.

Doctors and nurses enhance and support each other practice. In [Mrs A's] case, it is possible communication was insufficient and better reporting and advice may have changed the outcomes for her.

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Certification

I do also have concerns that the rest home was able to achieve certification against the Health & Disability Standards which was required by the Ministry of Health for all levels of rest home care in October 2003. The documentation provided for consideration in this report would not have met those Standards.

Summary

Caring for confused elderly people is challenging and made more so when they develop other illnesses.

I believe however [Mrs A] did not receive satisfactory care in the time she was resident at the rest home and hope my comments will provide constructive comment for the Health & Disability Commissioner."

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Appendix 3 — Response from [the rest home]

"**<u>Clinical Records</u>**
All resident clinical records at [the rest home] have been addressed. Clinical records are now set up to contain the forms and documentation described in the policies which are in line with the Health and Disability standards. All files are set out in the same format with a contents page provide ease of access for the nursing and medical personnel to the resident's information. Process has been addressed to ensure that forms and documentation are completed in a timely way to address the residents care assessment needs. Recent audits show that documentation is being completed satisfactorily.

Assessment and Care Plans:
Within 24 hours of admission an initial assessment care plan is put in place. After three weeks a full care plan is developed by the primary registered nurse and input is sought from the resident and family. This care plan is evaluated and updated every six months or as necessary. If a resident develops new symptoms or an additional short term illness a specific short term care plan is put in place. Nursing staff are notified of changes to the care plans.

Each resident has a resident review every six months. Family are invited to attend this review. Input from family is noted and where necessary added to the care plan. Any concerns are documented and correction actions put in place.

Progress notes:
Progress notes need to clearly demonstrate the current condition and needs of the residents at any given time during the 24 hour period. To address this, entries are made by the nursing staff at the following frequency:

- Per 24 hours in the hospital (by an RN) when a resident is stable.
- 3 times per 24 hours in the hospital (by an RN) when a resident is unwell.
- 3 times per 24 hours to residents in the dementia unit with at least one of these entries by an RN.

Each entry must contain sufficient depth of information to guide nursing staff to provide a high standard of care to the resident during their duty. To address this we have provided nursing staff with documentation education and we follow up this education by providing one-on-one training opportunities. The nursing staff must write legibly and ensure that all their entries are signed. The entries are continually supervised and monitored by the new nurse leader and the clinical monitoring processes that have been implemented and improved.

Each residents file has a nursing staff signature list located in the front of the file to enable us to check the signatures at each entry.

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Clinical Monitoring
The process for clinical monitoring has been addressed and monitoring is now undertaken through several avenues.

Care Audits:
In addition to the random checks of clinical records, a monthly care audit programme has been implemented at [the rest home]. This audit is designed to address the health and disability care standards. The results of the audits are reviewed by the Manager and Nurse Leader and corrective actions put in place where necessary. The results of the audits are reported to the Quality Improvement Committee for further review. Results and information on the audit are provided to staff members through the various nursing staff meetings.

Accidents and incidents:
There is a reporting system for accident and incidents that occur. Nursing staff report the incidents using a specific form. All the incidents reported are fully investigated, recorded and systematically filed.

Quality Improvement Committee:
The Quality Improvement Team (QIT) was set up to oversee quality improvement issues. The QIT has become more robust with committee members taking action to correct any issues identified. The QIT meets monthly and reviews monthly clinical performance indicators, infection control surveillance reports, health and safety reports, provides input into the required corrective actions, complaints and compliments, and accident and incident reports. Minutes are recorded and circulated before they are filed. Staff are encouraged to participate in the quality meetings.

Team Meetings:
At the time of the complaint team meetings of key personnel were being held, the objective was to meet weekly, to discuss a number of day-to-day and key issues and to provide an avenue of communication to staff. The team was constructed in an attempt to create improved staff interaction. Previous to this there had been a strong individual ownership culture at [the rest home] which was preventing adequate avenues of communication as well as the sharing of knowledge and information.

Since reviews have been undertaken at [the rest home] and acknowledgement of unsatisfactory performance, the performance of the key team has improved markedly. The members of the team can now see the value of meeting together weekly; they are responsive and come to the meetings equipped with information

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and ready to provide input. The team consists of senior people from each department at [the rest home].

Clinical Performance Indicators (CPIs):
CPIs are obtained by the facility each month, these are forwarded to the National Quality Manager and analysed against [the rest home company's] other facilities. This benchmarking against the other facilities began in 2006. Overall facility results are provided to [the rest home] enabling us to measure our performance against the national performance measures.

Monthly Managers Report:
A Manager's report is completed monthly and forwarded to [the rest home company's] Chief Operating Officer (COO). This report has been set up and structured to provide the means to report on quality and risk. The report contains sections for both clinical and financial monitoring. The reports must be sent to the COO by a set time each month. The COO provides comment on the reports and requests corrective action where necessary.

Corrective Action Plans:
If required corrective actions are put in place following

- Monthly Audits
- Random checking of clinical notes
- Monthly Clinical Performance Indicator reviews
- Resident 6 monthly Care Reviews with residents and families
- Accident and Incident reports
- Concerns and Complaints
- Satisfaction surveys
- Care plan evaluations
- COO and Quality Manager comments on the monthly reports

Nursing Staff
Nursing staff issues that have been addressed include:

Nurse Leader:
A new nurse leader has been employed who has appropriate qualifications and who is committed to ensuring that the clinical care standards are raised. In addition the nurse leader's clinical practice is supervised by a highly qualified and experienced RN who is also a Manager within [the rest home company]; she also provides the nurse leader with mentoring. This supervision is given daily on the nurse leader's clinical practice. This will continue until all implementation of policy has reached a consistent high quality of care at [the rest home].

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The nurse leader and manager meet daily and more when necessary to discuss the resident's condition, review and investigate Accident and Incident reports, review concerns and complaints and to review staff performance. Issues with staff are addressed quickly and if necessary disciplinary action taken. Good communication exists between the nurse leader and site manager, information is readily shared and work is undertaken to meet the objectives and goals of [the rest home].

Registered Nurse Accountability:
Accountability of nursing staff was found to be inadequate at the time of the complaint at [the rest home]. Discussions with RNs have taken place regarding their professional responsibility and accountability to the residents. RNs are now held accountable for their documentation, development of care plans and progress notes entries. They are also responsible to both document and thoroughly report any changes in a resident's condition along with any concerns they may have about a resident to the nurse leader and/or manager. Follow-up on performance is undertaken and regular meetings are held with trained staff. Registered staff are given opportunities to provide input.

The increased expectation of RNs has resulted in a number of RNs resigning (due to [not] being prepared to accept these responsibilities and accountabilities). New RNs being recruited are informed of expectations at [the rest home] at the time of their recruitment interview. Performance reviews and performance management address any shortfalls identified. As a result, a more committed team of RNs is being established.

In your report it was suggested that registered Nurses could have been more proactive in assessing [Mrs A's] condition. We agree with this comment, we believe that improved practice of registered nurses addresses this issue.

Supervision:
Supervision of the Health Care Assistants (HCAs) was also found to be inadequate. This has been addressed by:

- improved process for handover of information to HCAs at the beginning of the duty
- improvement in verbal instruction during the duty
- the RN working closer with the HCAs during the duty to observe more closely their practice
- the RN following up on tasks and actions that they have requested the HCAs to perform
- making sure each individual resident has been given care during the duty according to the care plan.

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This serves to make both RN and HCA accountable. HCAs are instructed to be familiar with care plans and to provide the RN with input into care plans when necessary. HCAs have been provided with education on documentation to improve the quality of recordings.

A culture of team work is being encouraged where each member of the team picks up their responsibilities. Frequent meetings are held with the HCAs by the nurse leader and concerns and issues are addressed quickly. Performance reviews are linked into the actions taken to improved standards and education needs identified.

Education:
An annual in-house education plan is in place. This plan is designed to address the MOH education requirements for nursing staff. Education sessions are held weekly and attendance recorded. Each staff member has an individual training record filed.

Orientation:
In addition to improved education planning [the rest home] has implemented the [rest home company's] orientation program. This is a three month programme that covers all aspects of care, infection control, restraint minimization and health and safety. In addition orientation days are provided which consists of a full day workshop covering the key issues within the orientation program. Once the orientation programme has been completed HCAs are encouraged to link into the ACE training programme.

Quality Improvement in Staff Allocation:
We are constantly working on quality improvement and as a result of this we have again reviewed allocation of trained staff to the dementia unit and we are in the process of recruiting a trained nurse to provide additional supervision in the unit. This nurse will have responsibilities that include:

- Ensuring all resident cares are given according to care plans
- Prioritising and coordinating nursing tasks
- Clinical Records are in order and documentation completed
- Supervision of HCAs actively in the unit
- Identifying training needs of nursing staff allocated to the unit
- Communication with families and providing them with a clearer point of contact

<u>Communication</u>
It is acknowledged that communication to [Mrs A's] family was poor. It is important that family are notified early of changes in condition and that they are fully informed and involved quickly. Good communication to [Mrs A's] family would have ensured active participation from a family who wanted to be involved with decision making.

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Education has been provided to staff regarding communication. Registered Nurses are now responsive to contact family quickly. In addition we now have a specific family contact form in the clinical records and all discussions with families are recorded. This provides us with another avenue of monitoring.

The dementia unit nursing staff has been given specific education on communication. Staff have been instructed to welcome family when they visit the unit, to engage with the family rather than wait for family members to approach them, speak with family about their relative, informing them of their general condition, what they have been doing and any issues that need to be reported. If a family member asks for specific clinical information the HCA is to refer to the RN. The RNs are instructed to spend time with family to build a rapport and relationships. Names of nursing staff on duty are written up each shift so that family knows who is available. All staff wear name badges with designations so they are easily identified.

Complaints and concerns:
[Mrs A's] complaint highlighted that family concerns were not reaching management in a timely way. Since this time staff have received education regarding the complaints process. Staff are instructed to document small concerns quickly so that they can be addressed. Appropriate forms are completed and provided to the nurse leader or manager. This is proving successful at [the rest home].

The nurse leader and manager meet daily or as necessary to go over concerns received and all concerns are investigated thoroughly with corrective actions taken quickly.

General Practitioner (GP) Rounds
Your report identified gaps in communication with the GP and that the entries in the progress notes had not been thoroughly discussed with the GP. Registered Nurses are now conscious of this when undertaking rounds with the GP. As time and information must be organised well to be effective during the round, registered nurses are spending more time on preparation of information from a residents clinical records prior to the round.

<u>Dementia Unit</u>
A number of concerns were raised in the complaint that brought to light issues that needed to be further addressed.

1. **Resident wandering into [Mrs A's] room**

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[Mrs B] expressed concern regarding a male resident wandering into [Mrs A's] room and taking her belongings. The male resident was reported to also have on one occasion injured [Mrs A]. We have looked carefully at this problem (of residents wandering into rooms) and, although we did have activities in place to reduce this possibility, we acknowledge that the activities then were not sufficient to reduce this risk satisfactorily.

As a consequence, the activities program now in place runs two sessions per day, the activities provided address the specific needs of dementia residents, activities personnel have dementia training and the programme is reviewed by [the rest home's] divisional therapist and an occupational therapist. In addition to the activities programme HCAs provide residents with activities when necessary to distract them and settle them when necessary. This may involve doll therapy or simply looking at colourful picture cards and magazines. These additional activities are addressing the wandering issue. When a group of residents are in the lounge area an HCA is present with them.

2. Managing Challenging Behaviour

To improve the management of challenging behaviour the following has been undertaken:

- All nursing staff, including RNs and activities staff, have been provided with additional education on managing challenging behaviour.
- All residents have a managing challenging behaviour form in their clinical records. This form is a tool to identify objectives for the residents, identify triggers to behaviour change and develop and implement strategies for nursing staff to better care for the resident. This means that strategies are individualised for the resident. The forms are completed by the RN when developing care plans. HCAs assist RNs and provide input.

3. Dementia Unit Environment

To assist with the above issues it was also necessary to review the unit environment. The dementia wing was a newly refurbished unit at the time of [Mrs A's] stay and, although the unit was pleasantly decorated and furnished, a review of the environment has taken place.

Expert advice was sought on the preferred environment for a dementia unit and improvements have been made as a result of this advice. Items such as pictures that represent the era and scenes that our residents can relate to have been purchased and placed on the walls. This provides the residents with opportunities to bring back long term memories. Softer colours have been introduced to produce a more homely and calming environment, additional soft furnishing introduced and flower arrangements placed so that residents can enjoy touching them and rearranging them if they wish.

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The outside garden has been planted with additional colour and an area provided for residents to do their own gardening if desired. The unit grounds are designed to enable the residents to walk around if they desire and to spend time with family when they visit.

Name plates on resident doors now include a picture of something that is relevant and familiar to them, this may simply be a picture of cards, a man fishing, a picture relevant to a culture or hobby. These familiar pictures assist the resident to locate their own room.

All these changes have produced a much friendlier and warm environment for residents and their family.

4. Medications
Medications were reviewed and nursing staff corrected following [Mrs A's] complaint. Nursing staff have been reminded of risks when administering medication to dementia residents, and to take more time with the dementia residents. Family members are no longer asked to apply creams or give medications.

We acknowledge that this was not good practice and have taken the necessary actions to correct it and prevent a reoccurrence."

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