Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 21HDC00191)

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Executive summary

1. This report discusses the care provided to an elderly woman when she was a resident at Ranfurly Manor (Promisia Healthcare Limited). The woman fell from her wheelchair and injured her ankle. However, it was nine days after the incident before an X-ray was taken and a fracture was diagnosed. During the nine days, the woman expressed pain frequently and requested pain relief. The report highlights the need for staff to assess changes in a resident’s condition appropriately, understand and follow relevant policies, and escalate any concerns about a resident’s care quickly.

Findings

2. The Aged Care Commissioner found that by placing the woman into her electric wheelchair despite the safety concerns documented in her care plan, Ranfurly Manor failed to provide an appropriate standard of care. The Aged Care Commissioner was also critical that multiple staff failed to use an appropriate pain assessment tool consistently and failed to recognise the need to escalate the woman’s care. Accordingly, the Aged Care Commissioner found Ranfurly Manor in breach of Right 4(1) of the Code for failing to provide services with reasonable care and skill.

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Recommendations

3. The Aged Care Commissioner recommended that Ranfurly Manor provide a written apology to the family and provide HDC with an update on the changes made to the process for communication with family when adverse events occur. It was also recommended that Ranfurly Manor undertake audits of its protocol for review of residents by registered nurses, and an audit of its pain management policy and staff compliance with the medication and falls policy; provide evidence of a staff study day for communication and documentation; and use an anonymised version of this report as a basis for staff training at Ranfurly Manor.

Introduction

4. This report is the opinion of Carolyn Cooper, Aged Care Commissioner.

5. The report discusses the care provided to Mrs A (in her eighties at the time of events) by Promisia Healthcare Limited (trading as Ranfurly Manor).

6. On 28 January 2021, this Office received a complaint from Ms B about the care provided to her mother, Mrs A, at Ranfurly Manor. The complaint concerns the lack of escalation of care following a fall, and the lack of communication with family following the fall.

7. The following issue was identified for investigation:

- *Whether Promisia Healthcare Limited provided Mrs A with an appropriate standard of care in November 2020.*

Background

8. Mrs A had been a resident of Ranfurly Manor from 2014. At the time of these events, she was receiving hospital-level care.

9. Mrs A had several co-existing conditions, including Parkinson's disease,[1] osteoarthritis,[2] lumbar spinal stenosis[3] with nerve root impingement, and a right femur periprosthetic fracture.[4]

10. Mrs A's son, Mr C, was her primary contact person.

Care plans

11. An interRAI assessment (long-term care) completed on 15 October 2020 noted that Mrs A was a high falls risk. Mrs A's care plan stated:

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[1] Parkinson's disease is a brain disorder that causes unintended or uncontrollable movements such as shaking, stiffness and difficulty with balance and co-ordination.

[2] Osteoarthritis is a long-term condition that causes the gradual breakdown of soft tissue and certain joints.

[3] Lumber spinal stenosis is a narrowing of the spinal canal in the lower back, which may cause pain or numbness in the legs.

[4] A periprosthetic femur (thigh bone) fracture is a broken bone around or very close to the metal and plastic parts of a hip replacement.

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> '[Often Mrs A will] make dangerous decisions around her mobility function, will try standing up and make an attempt to walk to her shelves when she knows she is unable to support herself, will ask the staff to set her up in her electric wheelchair but is unable to use this as she poses a safety risk to herself and others due to frequent mishaps.'

12. The care plan also noted that Mrs A was not to use her electric wheelchair 'due to safety reasons' and that staff must not put her into the chair, even though she might try to convince staff that she could still use it.

13. In terms of mobility, Mrs A required the assistance of two people using a standing hoist[5] for all transfers, owing to her high falls risk. It was also noted that her call bell should be in reach at all times, as she would 'sometimes attempt to stand herself, believing she [could] still walk'. It was documented in the clinical notes that Mrs A had no issues using the call bell.

Incident

14. Progress notes on 7 November 2020 document that Mrs A asked to be placed into her electric wheelchair 'while her son fixed her "daily use" chair', and so staff moved her into her electric wheelchair.

15. At 11.50am, Mrs A was found on the floor of her room by a carer, who rang the emergency bell for assistance.

16. Mrs A told staff that she had been sitting in her electric wheelchair and had leaned forward to retrieve something from her tray table and had slid down from the wheelchair. The attending registered nurse noted:

> 'Head to foot check done. No injuries noted. Flexion and extension at both extremities are possible. No signs of any fractures. [Complained of] pain on both lower legs 2/10 [on pain scale] given her regular panadol with good effect. Transferred her to her bed with sling hoist.'

17. It was documented that neurological observations were not taken as Mrs A had informed the nurse that she did not hit her head.

Pain management

18. Mrs A's interRAI assessment (long-term care plan) reflects that prior to this incident, Mrs A had had daily pain in her shoulders, which required a fentanyl[6] patch and PRN[7] morphine,[8] and that she could communicate and describe her pain to staff.

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[5] Standing hoists are used to secure a person while transferring them from a seated position to a standing position.

[6] Fentanyl is a strong opioid pain medication used to treat persistent or severe pain.

[7] PRN (pro re nata) refers to a medication that is not regular but can be requested and taken as needed (as prescribed).

[8] Morphine is a strong opioid medication used to treat severe pain.

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19. The prescription for Mrs A's PRN morphine was written in June 2020 and was for oral liquid morphine 2.5mg to be taken as required for pain, every four hours up to a maximum of three times a day.

20. Mrs A's care plan stated that she had regular hallucinations due to polypharmacy[9] and the progression of her Parkinson's disease and, for this reason, she had not requested morphine prior to 7 November 2020. Ranfurly Manor told HDC that prior to Mrs A's fall on 7 November 2020, she 'had not used the morphine since being charted in June [2020]'.

21. Following Mrs A's fall on 7 November 2020, multiple entries in the progress notes and medication chart note that Mrs A was complaining of pain in her legs and feet. A table summarising when she complained of pain, or when a nurse or carer noted a change in her leg/foot or mobility, is included as Appendix A. The table includes information about whether the pain scale[10] was used to assess the level of Mrs A's pain, the response from the registered nurse, and whether or not pain relief was given and its effectiveness.

22. As reflected in the table, out of the 20 documented expressions of pain, the following was noted:

- The pain scale was used four times.
- Morphine was used six times.
- Paracetamol was used once.
- Mrs A's legs were elevated once.
- A registered nurse was informed twice.
- Out of the seven times pain relief was administered (morphine six times, paracetamol once), the effect on her pain was noted only four times.

Emergency Department (ED) admission

23. On 16 November 2020, nine days after Mrs A's fall, a registered nurse expressed concern to the Clinical Manager that Mrs A's ankle did not appear to be improving and she was still complaining of discomfort. The nurse was directed to fax a general practitioner (GP) at a medical centre for an urgent review.

24. The fax noted that Mrs A had fallen from her electric wheelchair on 7 November 2020 and that she still had right ankle pain and that staff queried whether it was a soft tissue injury or a fracture. The GP notes state that Mrs A had fallen out of her wheelchair on 7 November, but the GP had been '**only notified today**' (emphasis added). Mrs A was referred for an X-ray of her right foot that same day (16 November). The X-ray showed that Mrs A had

[9] 'Polypharmacy' is described as having to take a large number (usually more than five) of drugs to treat diseases and other health conditions.

[10] A pain scale is a pain assessment tool used nationally and internationally. The scale is numbered from zero — meaning no pain, up to ten — meaning the worst possible pain. As pain is subjective to the person, the person will be asked to rank their pain from 0–10. The number is recorded and used to guide pain-relief interventions.

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sustained a right ankle trimalleolar fracture.[11] Ranfurly Manor was advised that the fracture was unstable and that Mrs A should be taken to ED for a cast.[12]

25. ED clinical notes from 17 November note that Mrs A had had '[p]ain in [her] ankle since [a fall from her wheelchair on 7 November] but only just had [X-ray] … today'. The notes also document that the injury was '10 days old so may not be able to improve this much and I suspect that her ankle joint may not be easily pushed to 90 degrees'. A cast was applied to Mrs A's right leg below her knee. ED staff instructed Ranfurly Manor that Mrs A was not to weight bear and was to attend the fracture clinic in a week's time. She was discharged back to Ranfurly Manor for ongoing management.

Post-hospital treatment

26. Clinical notes from Ranfurly Manor show that on her return, Mrs A appeared to be 'comfortable', in 'good spirits', and 'content', and even 'maintained a great sense of humor'.

27. The notes also indicate that when staff enquired about Mrs A's leg pain, she replied that she was 'fine at the moment' and declined PRN pain relief and said that she 'didn't have any pain [in her foot]'. Clinical notes after 17 November 2020 reflect that Mrs A continued to deny any pain in her right leg and declined PRN pain relief when offered.

28. A short-term care plan for Mrs A was developed for the 6–8 weeks following her diagnosis of an ankle fracture.

Communication with family and incident form

29. Ranfurly Manor told HDC that it made attempts to contact Mrs A's primary contact (her son, Mr C). The 'Family Contact form' records that Mr C was called at 2.10pm on 7 November regarding the fall, and that a voice message was left. Ranfurly Manor told HDC that it considers that its staff involved family in an 'appropriate and timely manner'.

30. However, it appears that no further attempts were made to contact Mr C. It is also unclear which of Mr C's telephone numbers was used, as both a home number and a cellphone number were recorded for him. Ms B (Mrs A's daughter/complainant) told HDC that her brother did not have any missed calls or voicemail messages. HDC was unable to obtain a telephone log for Ranfurly Manor.

Further information

Ranfurly Manor

31. Ranfurly Manor accepted that the pain management and assessments were not consistent with Mrs A's progress notes, and the effect of the pain relief was not documented. Ranfurly Manor stated that although carers noted that Mrs A had pain, it was not always communicated to the registered nurse in a 'timelier manner'.

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[11] A trimalleolar fracture is a break in the ankle joint in three places — the lower part of the fibula near the ankle joint, the inner part of the lower tibia near the ankle joint, and the back part of the tibia that is located at the level of the ankle joint.

[12] Casts are supportive devices used to keep an injured bone in place while it heals.

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32. Ranfurly Manor acknowledged that 'there is always room for improvement with documentation, knowledge, skills and standards of communication'.

Medication management policy

33. The Nursing Council of New Zealand notes four domains of competence that need to be met to practise as a registered nurse in New Zealand.

34. Domain two: Management of nursing care, competency 2.1 provides (in relation to medication management) that a registered nurse:

> 'Administers interventions, treatments and **medications** … within legislation, codes and scope of practice; and according to authorized prescription, **established policy and guidelines**.' (Emphasis added.)

35. At the time of these events, Ranfurly Manor had an established medication management policy (March 2019), the purpose of which was to 'ensure the safe and effective management of all medications at Ranfurly Residential Care Centre'.

36. The policy provided that it was the responsibility of the registered nurse/enrolled nurse to document 'information regarding medication administration, including the effects of the medication'. The 'administrator[13]' also had responsibility to monitor changes in the resident's health status and respond accordingly. There was also a prompt to include a comment on why a PRN medication had been given and its effect on relieving the pain.

Falls prevention and management policy

37. The purpose of the falls prevention and management policy (December 2019) was to 'minimize the risk of residents falling and to promote effective management of residents after they fall'.

38. The policy stipulated that to achieve this, residents would need a falls care plan based on their interRAI falls risk assessment, and that all falls were to be reported through the Accident and Incident Management (AIMS) system. This was so that trends could be identified and strategies implemented. The policy also provided that the falls were to be documented in the resident's progress notes, and that the next of kin was to be advised.

39. The policy also notes: 'Any resident who is assessed as at risk of falls must have strategies included in their nursing care plan to help minimize the risk of falls.'

Response to provisional opinion

40. Ms B was given the opportunity to respond to the 'information gathered' section of the provisional opinion, and she stated that she was happy with the record of events. Ms B also said that she would like Ranfurly Manor to apologise.

[13] An 'administrator' in this context refers to the registered nurse or enrolled nurse who gives the person/ resident the medication.

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41. Ranfurly Manor was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. It accepted the proposed findings and recommendations in relation to Mrs A's care. Ranfurly Manor also told HDC that it 'recognises the pain and distress suffered by both Mrs A and her family and wishes to apologise for those failings'. In addition, Ranfurly Manor told HDC:

> '[Ranfurly Manor is] confident the changes that have been made following the receipt of this complaint have adequately addressed the concerns the HDC has in relation to the care Ranfurly provides. The well-being and care of our residents is paramount, and the processes we have implemented will ensure we can provide the best possible care.'

Opinion: Promisia Healthcare Limited (trading as Ranfurly Manor) — breach

42. First, I acknowledge the distress that this event has caused Mrs A's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Ranfurly Manor was appropriate, I considered in-house clinical advice from RN Victoria Simon and RN Hilda Johnson-Bogaerts (Appendix B).

Falls risk management

43. Mrs A was assessed as a high falls risk, and this was documented in her care plans. It was also documented that she would try to walk despite knowing that she could not support herself. The care plan also stipulated that she was not to be put into her electric wheelchair as she could no longer use it safely, and that she would try to convince staff that she could.

44. RN Johnson-Bogaerts advised that the decision to move Mrs A into her electric wheelchair on 7 November 2020 was a moderate departure from accepted practice. RN Johnson-Bogaerts noted that the instructions not to place Mrs A in her electric wheelchair were in her care plan, and staff were responsible for providing care in line with the care plan. Staff who were caring for Mrs A had a duty to know the instructions in the care plan, and it was the responsibility of any person who changed the instructions to communicate this clearly to other staff.

45. I accept RN Johnson-Bogaerts' advice, and I am critical that staff placed Mrs A into her electric wheelchair despite her care plan stating that she was a high falls risk and her electric wheelchair was not to be used. In my view, this raises concerns about staff adherence to care plans and the manner in which important information about residents' care is communicated between staff at Ranfurly Manor.

Medication management

46. Over the nine-day period following Mrs A's fall on 7 November 2020 and up until the GP consultation on 16 November, there were 20 documented reports of pain in Mrs A's right ankle and swelling in her right leg, foot, ankle and shin.

47. RN Simon advised that although the nursing progress notes reported 'pain', there was no documentation of pain assessment follow-ups by registered nurses from 7 November, and,

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despite there being records of pain medication being administered, largely the effectiveness of the medications on Mrs A's pain was not documented.

48. The Nursing Council of New Zealand competency 2.1 provides (in relation to medication management) that a registered nurse:

> 'Administers interventions, treatments and medications … within legislation, codes and scope of practice; and according to authorized prescription, established policy and guidelines.'

49. RN Simon considered that nursing staff at Ranfurly Manor did not adhere to this competency in their management of Mrs A's pain. RN Simon advised that this omission represented a moderate departure from accepted practice.

50. I accept RN Simon's advice, and I note that over the nine-day period following Mrs A's fall on 7 November 2020, there were 20 entries in which she had expressed pain in her legs and/or ankles. There was also evidence that she had requested PRN morphine six times over the nine-day period, which she had not needed since June 2020. I am critical of Ranfurly Manor's management of pain-relief medication, and the lack of consistent documentation regarding use of the pain scale and the effect of the medication on Mrs A's pain.

Escalation of care

51. Mrs A's fall occurred on 7 November and, as noted above, she complained of pain 20 times between 7 and 16 November. Swelling had been noted on 8 November 2020. However, her care was not escalated to a GP until 16 November 2020. The GP noted that Mrs A had fallen out of her wheelchair on 7 November, but they 'were **only notified today**' (emphasis added). Clinical notes from the public hospital on 17 November also state that Mrs A had had pain in her ankle since her fall on 7 November, but '**only just had [an X-ray] … today**' (emphasis added).

52. RN Simon advised:

> 'In relation to the appropriate escalation of care and request for GP review from the clinical documentation it is evident [Mrs A] had foot, ankle, leg pain and associated leg swelling almost immediately [following her fall] and that an x-ray to rule out a fracture should have been considered.'

53. RN Simon stated:

> 'The usual way to determine if a fracture had occurred is to have an x-ray especially if the **resident continues to complain of pain** and has difficulty standing and other symptoms of foot, ankle, **leg and shin swelling.**' (Emphasis added.)

54. RN Simon noted that in this case, the X-ray did not occur until 10 days after Mrs A's fall, despite her documented complaints of pain.

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55. RN Simon considered that the delay in escalating Mrs A's care to a GP constitutes a moderate departure from accepted practice. I agree with this advice, and I am critical that over a nine-day period there were 20 documented expressions of pain from Mrs A, yet this was not escalated to the GP until nine days after her fall.

Adequacy of Ranfurly Manor's policies

56. Ranfurly Manor told HDC that at the time of these events it had policies in place in relation to medication management, falls prevention, and the management of head injuries. However, as outlined above, there were several instances in which the policies were not followed. In particular:

- The medication management policy was not followed correctly, as the pain scale was used inconsistently and the effect of medication on Mrs A's pain was not noted consistently.
- The falls prevention policy was not followed correctly in that Mrs A was assessed as a high falls risk (as she was unable to mobilise independently) but she was placed in her electric wheelchair despite her care plan stating that this was a safety concern.

57. RN Simon noted that while the policies in place at the time were appropriate, the staff did not follow them.

58. I accept RN Simon's advice and note that this investigation has highlighted that although the various policies in place at Ranfurly Manor to guide resident care were in themselves sound, the fact that multiple staff did not follow them consistently meant that service delivery was sub-optimal.

Other comment

Communication with family

59. Ranfurly Manor documented that it attempted to call Mr C on 7 November 2020 to advise him of the fall, but he did not answer and so a voicemail message was left. Conversely, Ms B told HDC that her brother did not receive a telephone call or voicemail notification. On balance, I allow the possibility that Ranfurly Manor did try to call Mr C once on 7 November. While I consider that this aspect of care did not depart from an appropriate standard (as guided by my advisors), I note RN Johnson-Bogaerts' advice that further attempts to contact family should be made if there is no response to an initial call. I encourage Ranfurly Manor to reflect on my comments and those of my advisor.

Conclusion

60. In summary, I find that Ranfurly Manor did not provide an appropriate standard of care to Mrs A between her fall on 7 November and her admission to ED on 16 November, for the following reasons:

a) Mrs A was placed into her electric wheelchair on 7 November 2020, despite having been assessed as a high falls risk and the care plan stating that she should not use her electric wheelchair due to safety concerns.

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b) Multiple staff failed to use an appropriate pain assessment tool consistently and to monitor, assess and manage Mrs A's pain adequately between 7 and 16 November 2020.

c) Despite numerous expressions of pain recorded in the progress notes between 7 and 16 November 2020, staff failed to recognise this and to escalate Mrs A's care to the GP earlier.

61. Consequently, Mrs A's pain was not assessed and responded to in an appropriate and timely manner, and this resulted in a delay in the investigation and diagnosis of her fractured ankle. The widespread failure by multiple staff to follow relevant policies demonstrates a service delivery failure and, accordingly, I find that Promisia Healthcare Limited (trading as Ranfurly Manor) failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Changes made

62. Ranfurly Manor told HDC that it made the following changes as a result of these events:

- In April 2021 it moved to an electronic resident monitoring programme called 'Health Care Solution Limited' ('HCSL'), which displays notes and adverse events to staff in a more accessible manner. Ranfurly Manor told HDC that this system communicates directly with its medication management tool (Medimap), which has 'assisted in efficient tracking of pain management and follow up by staff'.
- The clinical manager, team leaders and registered nurses now review adverse events and handover notes from their 'areas' daily.
- Registered nurses are now required to complete a 24-hour review of residents' notes so that any changes or concerns can be identified in a timely manner.
- A 'study day' was developed for communication and documentation.
- The process for handovers was refined, including that registered nurses now do a visual and verbal handover and raise any concerns to their team leaders, who then escalate to the Clinical/Quality Manager and/or the Facility Manager to ensure clinical follow-up.

Recommendations

63. I recommend that Promisia Healthcare Limited (trading as Ranfurly Manor):

a) Provide a written apology to Mrs A's family for the criticisms made in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

b) Provide HDC with an update on the changes made to the process for communication with family when an adverse event occurs for their family member, within one month of the date of this report.

c) Provide HDC with an example of the previously advised recent changes, as follows, within three months of the date of this report:

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i. Undertake an audit (10 files) of the 'RN 24-hour review' protocol to ensure that the purpose has been met —

- Any changes or concerns have been escalated to the team leader or clinical manager;
- The outcome for the resident has been noted; and
- Any corrective actions required and a subsequent plan for improvement have been noted.

ii. Provide evidence of the study day developed for communication and documentation.

iii. Undertake an audit of pain management (10 files) to demonstrate evidence of the use of the HCSL resident monitoring programme and where it communicates directly with Medimap when tracking pain management and follow-up.

d) Conduct random audits of staff compliance with the following policies for 10 residents at Ranfurly during the three months preceding the date of this report:

i. Medication policy

ii. Falls policy

The results of the audits are to be reported to HDC within six months of the date of this report. Where the audit results do not show 100% compliance, Ranfurly Manor is to advise what further steps will be taken to address the issue.

e) Use an anonymised version of this report as a basis for staff training at Ranfurly Manor, focusing on the breach of the Code identified. Evidence that this training has been completed is to be sent to HDC within six months of the date of this report.

Follow-up actions

64. A copy of this report with details identifying the parties removed, except Promisia Healthcare Limited (trading as Ranfurly Manor) and the advisor on this case, will be sent to HealthCERT and Te Whatu Ora | Health New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Timeline of expressions of pain from Mrs A and responses from Ranfurly Manor staff

Date and time	Concern	Pain scale	Response by RN	Effect on pain?
7 November 2020 at 4.26pm	Pain in legs	8/10	Oral morphine 2.5mg given	*Not noted*
7 November 2020 at 8.35pm	'[U]nable to stand due to pain in [right] ankle' and was feeling 'sore' after her fall earlier that day	*Not noted*	*Not noted*	*Not noted*
7 November 2020 at 11.20pm	Pain in legs Right lower leg was 'slightly red'	8/10	Oral morphine 2.5mg given	Good effect
8 November 2020 at 2.10pm	'[Right] shin is swollen just below the knee'	*Not noted*	RN informed	*Not noted*
8 November 2020 at 6.16pm	Pain in legs	10/10	Oral morphine 2.5mg given	*Not noted*
8 November 2020 at 8.25pm	'[V]ery tearful at the start of the shift' and in 'so much pain'	*Not noted*	*Not noted*	*Not noted*
8 November 2020 at 11.00pm	Pain in lower legs	*Not noted*	Oral morphine 2.5mg given	Good effect
9 November 2020 at 2.30pm	Complained of 'sore legs' after her fall	*Not noted*	Legs elevated	Good effect
9 November 2020 at 10.00pm	'Ankle is very painful to stand on'	*Not noted*	*Not noted*	*Not noted*
10 November 2020 at 2.30pm	Ankles are 'still very painful from [the] fall'	*Not noted*	*Not noted*	*Not noted*

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10 November 2020 at 11.05pm	Ankles were ‘very painful’ and was ‘upset’ with this pain	*Not noted*	*Not noted*	*Not noted*
11 November 2020 at 2.30pm	Complained of ‘sore ankles’ following her fall	*Not noted*	*Not noted*	*Not noted*
11 November 2020 at 9.30pm	Ankle was still sore and staff were ‘just being careful when lifting it’	*Not noted*	*Not noted*	*Not noted*
12 November 2020 at 12.05am	Pain in right ankle	6/10	Paracetamol 1g given	Minimal effect
12 November 2020 at 1.00am	Pain in right ankle	*Not noted*	Oral morphine 2.5mg given	Good effect
12 November 2020 at 9.30pm	‘Ankle is still sore’	*Not noted*	*Not noted*	*Not noted*
13 November 2020 at 9.05pm	‘Right ankle [is] still very sore’	*Not noted*	*Not noted*	*Not noted*
14 November 2020 at 3.30pm	‘[V]ery painful’ right leg and she was ‘very tearful’ that shift	*Not noted*	RN informed	*Not noted*
14 November 2020 at 3.36pm	Pain in right lower leg	*Not noted*	Oral morphine 2.5mg given	*Not noted*
15 November 2020 at 9.30pm	Foot is ‘still sore’	*Not noted*	*Not noted*	*Not noted*
16 November 2020 at 10.21pm	‘[S]till experiencing bad pain in [right] ankle’	*Not noted*	*Not noted*	*Not noted*

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Appendix B: In-house clinical advice to Commissioner

The following in-house advice was obtained from Aged Care Advisor RN Victoria Simon:

'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Ranfurly Residential Care Centre (Ranfurly). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Documents reviewed
I have been provided with the following information to base my review on: Facility Manager responses dated 14/2/2022 and 22/3/2021, [Mrs A] Ranfurly clinical documentation, and Complaint letter dated 28th January 2021.

Complaint
[Mrs A] was admitted to Ranfurly in December 2014 with Parkinson's disease, Osteoarthritis, Lumbar Spinal Stenosis with nerve root impingement and fell from her electric wheelchair in her room on the 7th November 2020. [Ms B] has some concerns about her care following her fall.

Review of clinical records
For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future. In particular, comment on: The adequacy of [Mrs A's] pain management, including the standard of the documentation.

Ranfurly Facility Manager 14/2/2022 response identified *"the pain management and assessments were not consistent with her progress notes and effectiveness of medications were not documented. Further, HCAs at times noted that [Mrs A] had pain however this was not always communicated to the RN on duty in a timelier manner"*. On reviewing [Mrs A's] clinical documentation it is unclear who are the author/s and their designation of some of the nursing progress notes for example on the 7th November at 2035pm and 2320pm; on the 8th November at 2300hrs; on the 11th November at 230pm and on the 13th November at 2105pm. There are a number of documented reports of pain in the (R) ankle, swelling in (R) leg, foot, ankle and shin from 2035pm on the 7th November 2020 and almost daily up to the GP consultation on the 16th November. I concur with the Facility Manager response that despite nursing progress notes reporting pain, there are no RN follow up pain assessments from as early as 2035pm on the 7th November and although records of pain medication being administered the effectiveness of medications were largely not documented.

Competencies for registered nurses (Nursing Council of New Zealand: 2010)

Domain Two: Management of nursing care competency

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2.1. States: provides planned nursing care to achieve identified outcomes.

Indicator four states: Administers intervention, treatments and medications within legislation, codes and scope of practice, and according to authorised prescription established policy and guidelines.

I am of the view that this competency was not met by nursing staff and it would be viewed similarly by my peers. In the circumstances, I consider this to be a moderate deviation from accepted and appropriate nursing practice.

The adequacy of the timing of the request for GP review on the 16th November 2020, including whether or not you consider that this was done in an appropriate and timely manner.
In relation to the appropriate escalation of care and request for GP review from the clinical documentation it is evident [Mrs A] had foot, ankle, leg pain and associated leg swelling almost immediately and that an x-ray to rule out a fracture should have been considered. In the circumstances I consider this to be a moderate deviation from accepted and appropriate practice and it would be viewed similarly by my peers.

The adequacy of the falls risk management, including whether you consider it was appropriate in the circumstances, for [Mrs A] to be placed in her electric wheelchair in the absence of her fixed chair.
Ranfurly Facility Manager responses included her care plan which states "*ensure staff do not put [Mrs A] into the Electric Wheelchair as she can sometimes try to convince them that she is still capable of using this*". The staff statement included "*[Mrs A] is generally extremely persuasive towards staff and I cannot recall if [Mrs A] asked to be in that chair that day. I have no recollection of the son informing staff she no longer required to be in the chair after he had left*". In relation to the falls risk management and care plan, clearly staff were advised not to put [Mrs A] in her electric wheelchair. Unfortunately, in the absence of her fixed chair a decision was made to use the electric wheelchair. It is unclear how this occurred and in hindsight this was a mistake.

The adequacy of Ranfurly's Head Injury Guidelines policy, including whether or not you consider that it was appropriately followed by [the nurse] in this case.
Ranfurly's Head Injury Guidelines policy is adequate and [the nurse] wrote "*She did not hit her head*". Despite this being an unwitnessed fall where neurological observations is required I accept for a competent resident saying she did not hit her head accompanying by the attending RN conducting a head to toe assessment which occurred that the RN concluded she did not suffer a head injury. In these circumstances this is acceptable and appropriate care.

The adequacy of Ranfurly's, "Falls Prevention & Management" and "Medication Management" policies in place at the time of the events.
Ranfurly's policies are appropriate however the staff did not follow the policies. For example it is policy to evaluate the effectiveness of medication and also complete pain assessments. The usual way to determine if a fracture had occurred is to have an x-ray especially if the resident continues to complain of pain and has difficulty standing and

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other symptoms of foot, ankle, leg and shin swelling. Clearly the application of the policies and follow up care was missing by a number of care staff from the 7th November 2020. Further, all falls or near misses are reported through the Accident and Incident Management to enable individual and facility-wide trends to be identified and strategies to be implemented accordingly. In the circumstances I consider this to be a moderate deviation from accepted practice and it would be viewed similarly by my peers.

The adequacy of Ranfurly's communication with [Mrs A's] family from 7 November 2020 to 30 November 2020.

Ranfurly Facility Manager 22/3/2021 response identified the RN had written on the 7th November 2020 at 1410pm "*called [Mr C] who did not answer so a voice message was left".* The next entries recorded on the 16th November at 1950pm "*phone call to [Mr C] to ask for an escort to attend the x-ray appointment"*. On the 17th November "*phone call update to [Mr C] on getting a cast*". On the 18th November *"message left re ED visit and plan of care by the CNM"*. It is not until the 23rd November at 1604pm that it is recorded that "*[Mr C] answered the call*". The challenge with communication is the Facility can only document when they call and if the person does not answer a general message to state the purpose of the call and to ask the person to call back. This becomes problematic if the person does not receive any messages or phone calls and certainly it is difficult to ascertain what was written and what occurred. It is appropriate for families to ring to discuss any issues or concerns as appropriate.

Clinical and Cultural advice

Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice (Nursing Council of New Zealand, 2011) states: "Cultural safety is an outcome of nursing education [and nursing practice] that enables **safe service to be defined by those who receive the service**". [Mrs A's] health deteriorated following her fall on the 7th November 2020 and although she was seen by the GP and had an x-ray it was revealed she had suffered two broken bones. I acknowledge the Facility Manager comment "we believe there is always room for improvement with documentation, knowledge, skills and standards of communication" and a communication education session was developed. Handovers have been refined and any concerns identified are managed in a more time effective manner and there has been increased reporting by the Team Leaders, reviewed by the Clinical and Quality Managers to ensure clinical follow up and completed required documentation and reports discussed at weekly Management meetings and a copy of the reporting template attached. Additionally, the Facility is moving towards a paperless patient management system which will allow a greater overarching supervision of residents and their care needs. This is appropriate training and reporting. I would encourage the Facility staff to continue to work on their communication with the family to ensure they understand the care being discussed and they know the staff are monitoring and will respond to their concerns so that this complaint doesn't occur to another family.

Victoria Simon, RN MN and MSocSc
Aged Care Advisor Health and Disability Commissioner"

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As RN Victoria Simon has left HDC, I asked Aged Care Advisor RN Hilda Johnson-Bogaerts to quantify (no departure, moderate departure, severe departure) the following points in RN Simon's advice. RN Johnson-Bogaerts provided the following advice on 1 September 2022:

> 'Point 3 — *"The adequacy of the falls risk management, including whether you consider it was appropriate in the circumstances, for [Mrs A] to be placed in her electric wheelchair in the absence of her fixed chair."* I note there was no departure identified here, would you want to identify a departure for this?
>
> I would consider this in the circumstances to be a moderate departure from accepted practice. I have come to that conclusion because instructions were in place in the care plan and it is the responsibility of staff providing care that they provide this in line with the care plan. While it is care staff duty to know the care instructions in the care plan it is also the responsibility of the person changing instructions to communicate this to care staff. Typically this would happen at hand-over time or any other transfer of communication platform. This brings up the concern how changes in care plans are communicated to all care staff and if there may be a systemic issue.
>
> Point 4 — *"The adequacy of the Ranfurly's Head Injury Guidelines policy …"* Would you be able to quantify a departure?
>
> Reading [RN Simon's] advice it would appear that she accepts the explanation and did not identify any departure.
>
> Point 6 — *"The adequacy of Ranfurly's communication with [Mrs A's] family from 7 November …"* — would you be able to specify the departure here?
>
> What [RN Simon] is saying is that it is a shared responsibility to make communication work. Staff have made notes when they left a message when there was no response. It seems like no departure could be identified however it may be appropriate to make a recommendation here that the carehome perhaps makes additional attempts to contact the family if no response received from messages left and perhaps agree on a second contact person if the first contact person cannot be contacted.'

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