Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Update from the HDC

Rose Wall
Deputy Commissioner, Disability

NZACA Conference
12 September 2018

Overview

Health and Disability Commissioner
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- HDC vision
- Data on complaints
- Areas of concern
- Case studies, and recommendations made

HDC Vision

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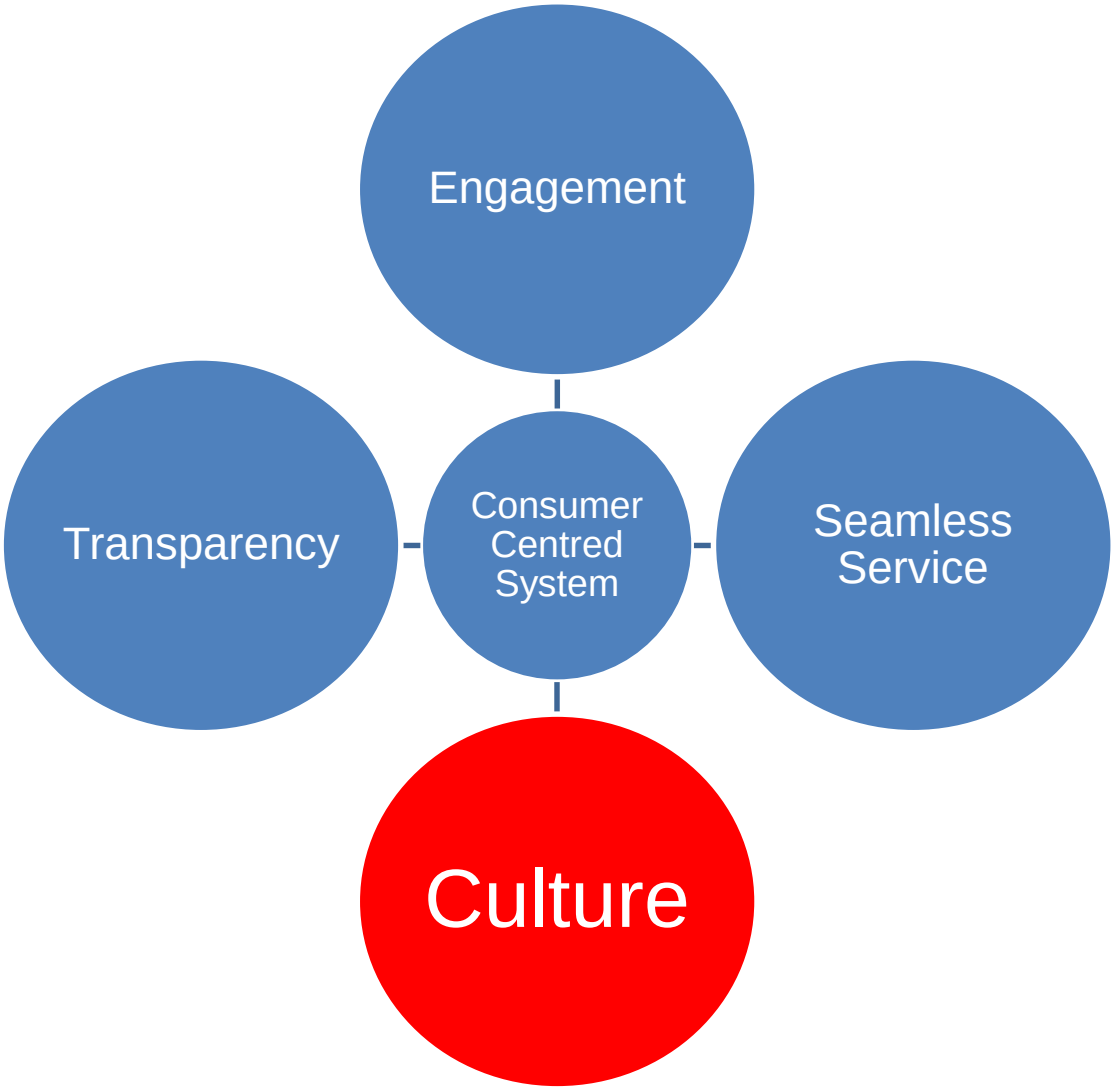

Complaints per year

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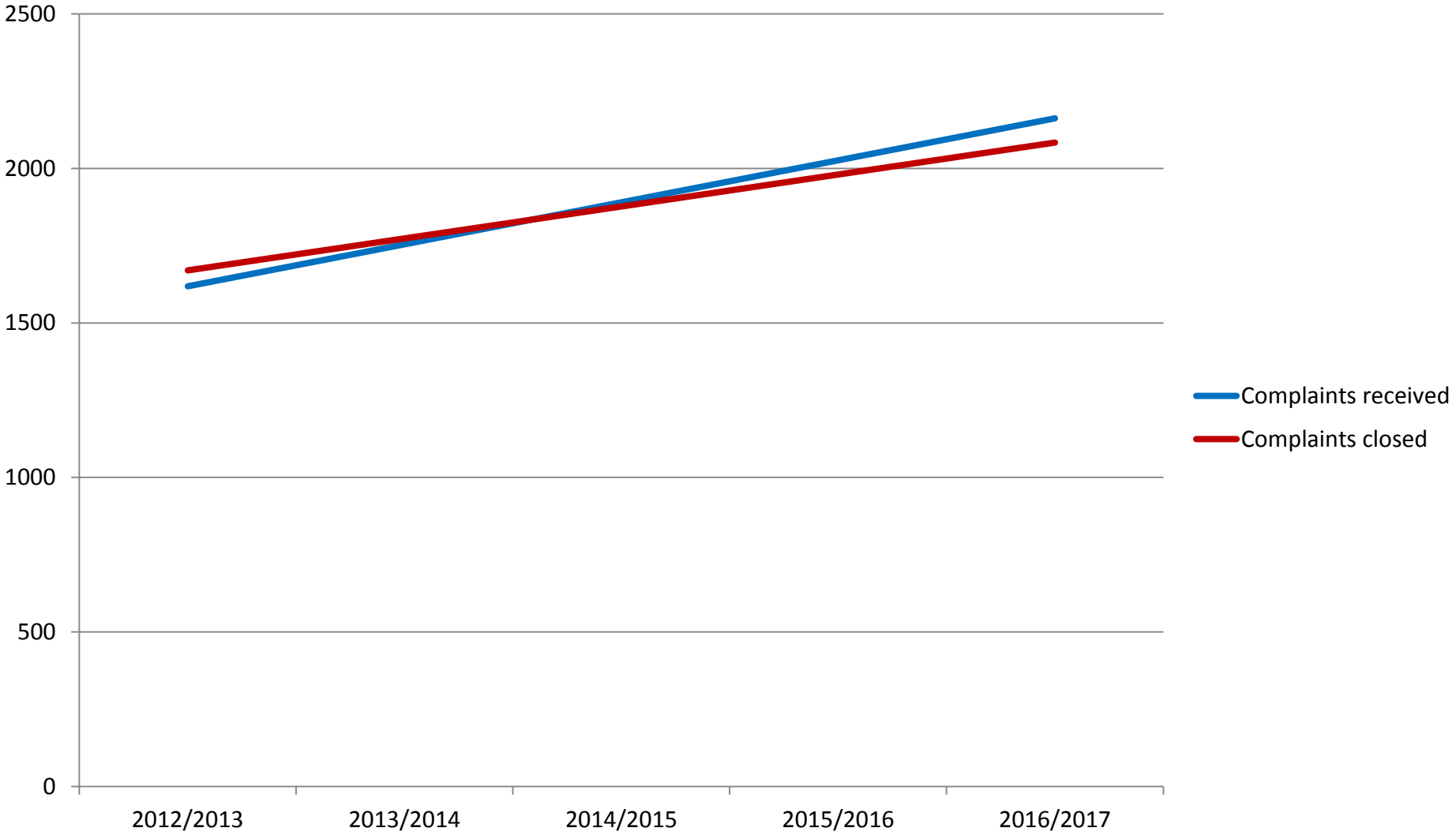
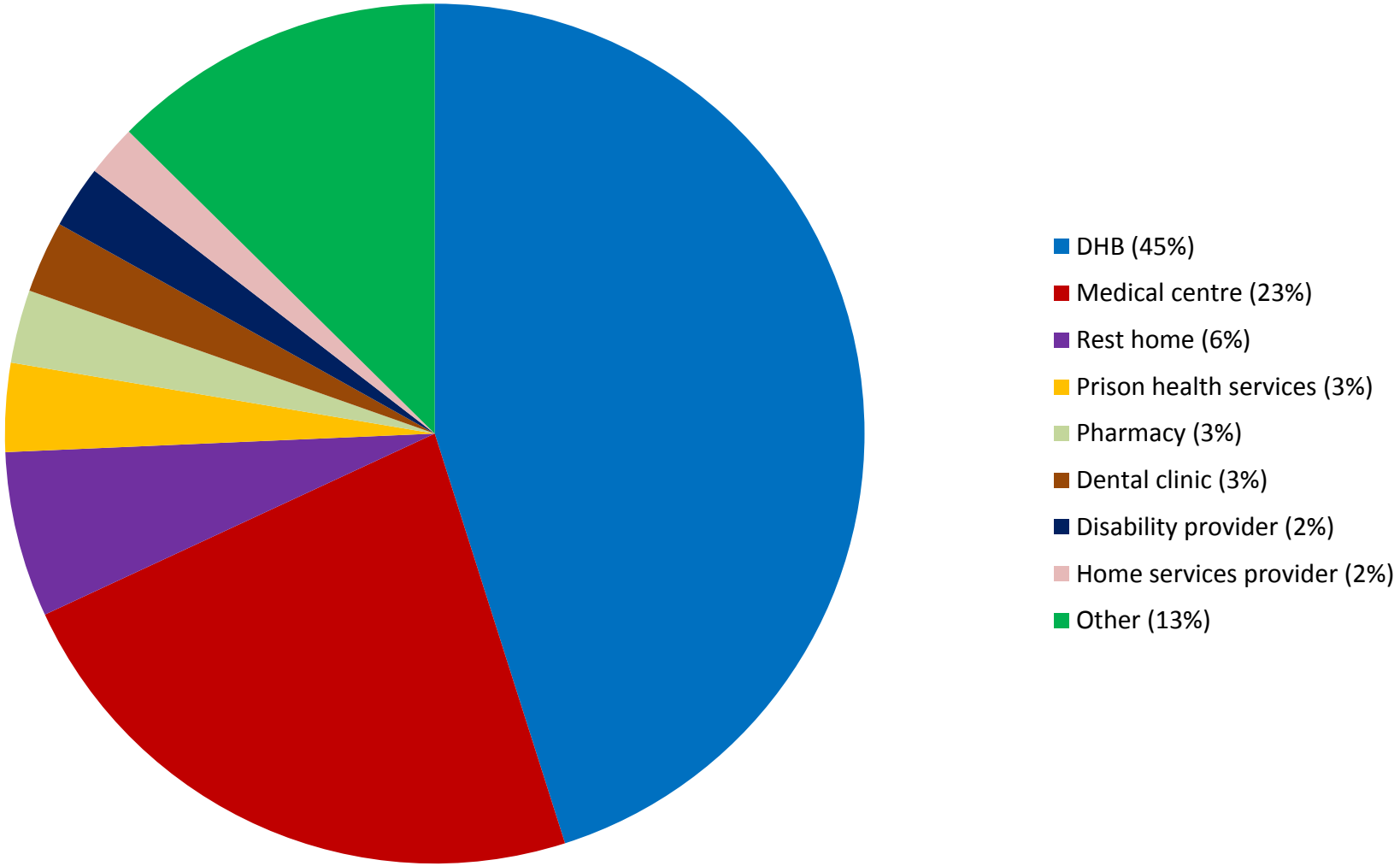


Who was complained about?

Group providers 2016/2017



Areas of concern
Rest homes

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- Communication – with family & between providers
- Deteriorating condition
- Falls
- Wound care
- Medication
- Fluid monitoring and nutrition
- End of life care

http://www.hdc.org.nz/media/300644/residential%20aged%20care%20report.pdf

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Case Study 1

Palliative care in rest home

13HDC00405

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- Woman with advanced pancreatic cancer admitted to rest home for palliative care
- Several times during her admission, the woman was noted by staff as being in pain on movement, and still in pain after pain relief was administered.
- Daughter also complained that mother in pain

Palliative care in rest home

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- Pain evaluation chart not completed; pain scale not used
- RNs did not carry out assessment, seek advice or report pain to senior staff or GP
- Poor documentation regarding care and treatment and discussions with family

Palliative care in rest home

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- Investigation did not focus on whether woman was experiencing pain; rather, issue was the process followed to monitor her pain levels generally, and when concerns were raised that she was in pain.
- Strong criticisms about care by RNs
- Failure to follow palliative care policy

Palliative care in rest home

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- **Individual nursing staff found in breach of Right 4(2) of the Code**
  - – failure to carry out formal pain assessment and to seek advice or report woman's pain or daughter's concerns
- **Clinical Nurse Manager found in breach of Right 4(1):**
  - – failure to demonstrate clinical oversight or leadership
- **Rest home found in breach of Right 4(1):**
  - – failure to ensure policies were adequate and followed appropriately by staff

Palliative care in rest home

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Recommendations to rest home:

- Update its Medication Policy
- Provide palliative care training
- Provide training about importance of comprehensive documentation
- Apologies

Nursing Council to consider review of two of the nurses' competence

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Case Study 2

Restraint, consent & competency - 16HDC00720

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- Man transferred to rest home hospital after a stroke, requiring a wheelchair
- EPOAs had not been activated
- Rest home consulted EPOA for property regarding his care
- Wheelchair not available, so used recliner chair with canvas belt tied around him
- Consent obtained for chair but not belt from EPOA for personal care and welfare; man not consulted

Restraint, consent & competency - 16HDC00720

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Rest home - breach:

- Failed to verify the man's legal status and competence (Right 4(1))

  It was not acceptable for the rest home to assume that Mr A was not competent to make decisions for himself, and this shows a lack of respect for him and little awareness of the psychological impact that the loss of autonomy can have on vulnerable residents.

Restraint, consent & competency - 16HDC00720

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Rest home - breach:

- Processes regarding restraint were unsatisfactory and the use of the canvas belt was not in accordance with the New Zealand standards or the rest home's own policy (Right 4(1))
- The canvas belt was used without the man's consent (Right 7(1)).

Restraint, consent & competency - 16HDC00720

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Recommendations to rest home:

- Further education to staff
- Audit of current residents' records
- Review incident form templates
- Apology to man

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Case Study 3

Wound care and deteriorating condition

15HDC00423

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- Woman in hospital-level care at rest home
- Multiple sclerosis and other conditions
- Pressure area observed; wound care plan and evaluation record commenced
- Nursing staff recorded increasing deterioration in wound and woman's general condition over next fortnight but no action taken

Wound care and deteriorating condition

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- Sometimes given zopiclone in early hours of morning
- Later that month, woman's condition and wound deteriorated further – no medical advice sought
- Administered zopiclone at 2pm
- Delayed response to deterioration
- Transferred to hospital

Wound care and deteriorating condition

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This case highlights the importance of aged residential care facilities having staff with adequate expertise and skill to support younger residents with chronic medical conditions and complex comorbidities. In such circumstances, medical, nursing, and support staff need to be alert to the resident's changing health status. Staff must assess, think critically, and respond appropriately to, deterioration in the resident's condition.

Wound care and deteriorating condition

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- **Rest home breached Right 4(1):**
  - Staff failed to assess, think critically and act appropriately
  - Staff continued to administer zopiclone at inappropriate times without reference to prescriber

- **Clinical Manager breached Right 4(1):**
  - failed to act on information relating to wound deterioration
  - failed to respond appropriately to Ms A's acute presentation.

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Wound care and deteriorating condition

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- **Unit Coordinator breached Right 4(1):**
  - failed to act on wound management issues
  - responded inappropriately to Ms A's acute presentation.

- **RN (allocated nurse) breached Right 4(1):**
  - wound management
  - administration of zopiclone

Wound care and deteriorating condition

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Recommendations to rest home:

Update HDC on:

- the finalisation and implementation of the pressure injury policy and education pack, and the Short Term Care Plans policy
- its implementation of the electronic medication management and electronic incident management systems
- the implementation of the proposed new role of roving Clinical Manager

DP referral

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