Waikato District Health Board
Rest Home

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC00572)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. In 2016, Mrs A, then aged 81 years, fractured her right leg. She was admitted to a public hospital, and a range of motion (ROM) brace was fitted to her leg and she was placed on 12 weeks' bed rest. A doctor gave a directive that the skin under Mrs A's brace was to be monitored for pressure sores, but this directive was not recorded in Mrs A's Patient Care Plan. The doctor also asked for Mrs A to be referred to the Pain Clinic, but the referral was not made.

2. On 4 Month2,[1] Mrs A was discharged from the public hospital to a rest home, and the rest home was advised that Mrs A was to remain on bed rest for 12 weeks. Mrs A developed a urinary tract infection, and symptoms that included severe pain and delirium, and was readmitted to the public hospital on 7 Month2.

3. A doctor at the public hospital noted a pressure area on Mrs A's right knee and sacral area. He instructed that the brace be removed, and the wound reviewed daily. This instruction was not entered into Mrs A's Patient Care Plan, and there is no documentation about whether the instruction was carried out.

4. On 14 Month2, Mrs A was discharged from the public hospital to the rest home. On 21 Month2, Mrs A was seen at the Fracture Clinic at the public hospital as an outpatient. Staff at the rest home did not remove the brace until 28 Month2, and a necrotic area of skin over Mrs A's knee was discovered. Mrs A was transferred to the public hospital, and she died the following day.

Findings

5. Waikato DHB's decision to manage Mrs A's fracture with a ROM brace was appropriate. However, the Deputy Commissioner was critical of a number of aspects of the care provided by multiple staff at Waikato DHB:

- The verbal handover instructions, provided at the first and second discharges, were not recorded adequately.
- On the first discharge, Waikato DHB did not clearly record the documents that were provided to the rest home, or provide instructions for the care of the brace and the skin underneath it.
- On the second discharge, Waikato DHB did not provide the rest home with all the necessary documents pursuant to its discharge policy, and did not note the existence of the pressure area or the care that was required for it.
- Directives given by the medical staff during the first and second admissions to the public hospital were not recorded in the Patient Care Plan, and were not actioned.

6. As a consequence of these actions, staff at the rest home did not have clear information about the appropriate care to be provided to Mrs A on discharge.

[1] Relevant months are referred to as Months 1–2 to protect privacy.

7. A deconditioning plan was not considered, and a referral to the Pain Clinic was not actioned. As a result, Mrs A did not have the benefit of the Pain Clinic's expertise.

8. The Deputy Commissioner found that while individual staff hold some degree of responsibility for their failings, the deficiencies indicate a pattern of poor co-ordination and communication, both within Waikato DHB and with the rest home. Numerous staff at Waikato DHB did not record key information about Mrs A's care in the appropriate documents, and when it was recorded it was not actioned. The handover information that was provided to the rest home was poor. This information, or lack of it, may have affected the care provided to Mrs A by subsequent healthcare providers. Accordingly, Waikato DHB failed to provide services with reasonable care and skill, and breached Right 4(1) of the Code.[2]

9. The Deputy Commissioner made adverse comments about the management of the brace by the rest home.

Recommendations

10. The Deputy Commissioner recommended that Waikato DHB conduct an audit of staff compliance with the discharge policy; update HDC on the results of the investigation into the development of the deconditioning plan for selected patients; update HDC on the review of its process for referral to the Pain Clinic; and provide Mrs A's family with a formal apology.

11. In 2018, the rest home's assets were sold, and the contracts of all staff were terminated. Accordingly, no recommendations have been made for the rest home.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Waikato District Health Board (DHB) to her mother, Mrs A. The following issue was identified for investigation:

- *Whether Waikato District Health Board provided Mrs A with an appropriate standard of care in Month1 and Month2.*

13. On 21 August 2018, the investigation was extended to include the following issue:

- *Whether the rest home[3] provided Mrs A with an appropriate standard of care in Month2.*

[2] Right 4(1) of the Code of Health and Disability Services Consumers' Rights states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] The rest home was sold in 2018. At that time, employment of all staff was terminated, and the assets were purchased by the new owner.

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

15. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
Waikato DHB	Provider
Rest home	Provider

16. Also mentioned in this report:

Dr C	Orthopaedic surgeon
RN D	Registered nurse
Dr E	Orthopaedic surgeon
RN F	Clinical Nurse Manager
RN G	Acting Clinical Nurse Manager
Dr H	Orthopaedic registrar
Ms I	Physiotherapist

17. Independent expert advice was obtained from Rosalind Jackson, a registered nurse (Appendix A), Jan Grant, a registered nurse (Appendix B), and Dr John McKie, an orthopaedic surgeon (Appendix C).

Information gathered during investigation

12 Month1 — admission to Waikato DHB

18. On 12 Month1, Mrs A, then aged 81 years, fractured the tibia[4] and fibula[5] in her right leg, and was taken to the Emergency Department (ED) at the public hospital. Mrs A had a complex medical background including chronic kidney disease, congestive heart failure, ischaemic heart disease, and type 2 diabetes.

19. Mrs A was admitted to the public hospital on 13 Month1, and assessed by Dr C, an orthopaedic surgeon. He told HDC that he considered the surgical options and concluded:

> "This would be a large operation with enormous risk. In particular the [surgical] procedure would be technically very difficult due to the likelihood of displacing the tibial tuberosity[6] and defunctioning the extensor mechanism (this would be un-reconstructable and severely disabling). Additionally [Mrs A] had poor bone mineral density compatible with osteoporosis. Thus, her bone was soft and it would be difficult to secure these types of prosthesis into her bone. I felt surgery therefore

[4] Shin bone.
[5] Leg bone located on the side of the tibia.
[6] Tibial tuberosity is an oval elevation on the anterior surface of the tibia.

> would have [a] very low chance of providing relief, a very low chance of providing any form of function to her leg and a significant chance of death."

20. Dr C told HDC that he discussed his assessment with his colleagues. He said:

> "At the meeting the consultants present gave the consensus opinion that [Mrs A] was not an operative candidate. We felt the fracture should be allowed to heal in a brace. If the brace could not control the fracture alignment, or if the fracture did not heal after 12 weeks of immobilisation, this decision could be reviewed."

21. Dr C said that he spent considerable time discussing his assessment with Mrs A's daughter. In response to her concerns that there was no discussion about deconditioning, he said:

> "I explained that there was a significant chance of death if the surgery was carried out at that time and, at best, the surgery may achieve a result of severe and permanent disability. I considered that this would have balanced the concern about deconditioning resulting from non-operative management."

22. Waikato DHB told HDC that it did not have a specific deconditioning plan. It said: "[T]hese considerations are generally and traditionally held within the nursing care plan."

23. Ms B told HDC that both she and her mother were concerned about the decision not to operate. She said that the Orthopaedic Team told her that surgery was "too high risk", but that she did not understand that to mean that surgery could result in severe and permanent disability.

24. On 14 Month1, a range of motion (ROM) brace was fitted to Mrs A's right leg, and she was placed on 12 weeks' bed rest. A ROM brace is made up of two metal hinges that are placed on the outside and the inside of the leg. The hinges are fastened together with straps. The brace is designed to restrict knee movement during rehabilitation. The leg is visible beneath the brace unless padding is applied to the leg.

25. On 15 Month1, a CT scan confirmed satisfactory fracture alignment, and Dr C decided to continue with brace management.

26. Dr C stated:

> "A very clear directive was given to monitor [Mrs A's] skin under the brace to ensure pressure areas were detected and managed accordingly. This was documented in the notes. During her first admission under my care no pressure areas were noted."

27. The clinical notes for 16 Month1 state: "Please ensure skin under brace is vigilantly checked for pressure areas." This information was not entered into Mrs A's Patient Care Plan.[7]

[7] A Patient Care Plan is a document that identifies the nursing orders for a patient and serves as a guide to nursing care.

28. Mrs A was prescribed paracetamol, aspirin, and oxycodone[8] to manage her pain. Dr C told HDC that he asked the resident medical officer to arrange a referral to the Pain Clinic on multiple occasions. However, there is only one entry in the clinical notes, dated 20 Month1, that records a plan to "[review] pain [medication] with pain team". The referral was not made.

29. Waikato DHB told HDC:

> "The nursing notes report offering pain relief, which at times was refused and other times accepted. There is good evidence that pain assessment and reporting was undertaken and that offering of regular pain medication was conducted. However, a referral for an assessment and advice in managing [Mrs A's] pain from the Acute Pain Service did not occur and could have been of benefit."

30. Between 20 Month1 and 4 Month2, Mrs A had a series of CT scans and X-rays. All images showed a satisfactory alignment of her fracture. During this period, the ROM brace was removed regularly, and the skin beneath it was checked. No pressure areas were noted.

Waikato DHB Admission, Discharge and Transfer Policy (Discharge Policy)

31. The Discharge Policy states:

> "Discharge to another healthcare service/facility …
>
> It is the responsibility of the discharging ward to supply the appropriate clinical documentation. In **addition to the discharge summary**, original clinical records and documents pertaining to the latest episode of care may accompany a patient moving to another Waikato DHB facility. [Emphasis in original.]
>
> Those records will include
>
> - A nursing transfer letter …
> - The patients comprehensive updated care plan …
> - Clinical records relating to the current episode of care …
> - Any other document deemed relevant."

4 Month2 — discharge from Waikato DHB

32. On 4 Month2, Mrs A was discharged from the public hospital.

33. RN D was the nurse responsible for discharging Mrs A. RN D recorded in the clinical notes: "[Handover to the rest home] done and all paperwork done." RN D did not document the conversation she had with the rest home or the written information that she handed over.

[8] Oxycodone is an opioid medication used for the treatment of moderate to severe pain.

34. RN D told HDC that she provided the rest home with a ROM brace cares brochure, the Patient Care Plan, and the discharge summary. She said: "I do not recall any further details due to the length of time."

35. The ROM brace patient information brochure (ROM brochure) provided general information to patients who have a ROM brace. It provided limited information about removing the brace or caring for the skin beneath the brace.

36. The Patient Care Plan recorded that a ROM brace was in place and that Mrs A was on bedrest. There are no instructions for the management of the brace or the skin beneath it.

37. The discharge summary recorded: "Brace applied to right leg and locked at 30 degrees. Repeat xrays show improved positioning of the limb." There is no mention of the management of the brace or the skin beneath it.

4 Month2 — admission to the rest home

38. The rest home told HDC that when Mrs A was admitted, the knee underneath the ROM brace was not covered, and the skin was intact.

39. The rest home said that it received the discharge summary and the Nursing Transfer Letter, but it did not receive a ROM brochure. The rest home did not say whether it received the Patient Care Plan, but a copy was provided to HDC by the rest home.

40. The Nursing Transfer Letter[9] recorded that Mrs A's skin was dry and fragile, that she was on bed rest, and that the key nursing interventions were "for weekly xrays/[increase pressure injury] intervention". The ROM brace was not mentioned.

41. The Care Record completed by the rest home on 4 Month2 stated: "Brace on [right] leg locked at 30 [degrees]. To be on bedrest for 12 weeks."

42. The Initial Assessment Care Plan completed by the rest home records: "Full bed rest cares. No exceptions." It also records that Mrs A's skin was intact and that she had a leg brace on her right leg.

43. Between 4 and 7 Month2, Mrs A developed a urinary tract infection, and symptoms that included severe pain and delirium.

44. The rest home told HDC:

> "[Mrs A] was assessed by [rest home] staff and GP, where it was clear that there were multiple co-morbidities, to be managed conservatively. When symptoms were unresolved despite management, [Mrs A] was sent back to [the public hospital]."

[9] A nursing transfer letter to age-related residential and community care dated 3 Month2.

7 Month2 — readmission to the public hospital

45. On 7 Month2, Mrs A was readmitted to the public hospital. She was seen by Dr E, the on-call orthopaedic surgeon, on 8 Month2. X-rays showed that the fracture had maintained alignment. Pressure areas were noted on the front of Mrs A's knee and sacral area.

46. Waikato DHB stated:

> "After readmission on [7 Month2] a mild pressure area was noted over the tibial tuberosity. This was managed with dressings and regular review with the brace removed to ensure it was not deteriorating."

47. The clinical note dated 10 Month2 records that Dr E's plan included: "Off brace daily with wound [review] and padding."

48. This instruction was not entered into the Patient Care Plan, and Waikato DHB told HDC that there is no documentation in the notes about whether this directive was carried out while she was in the public hospital.

13 and 14 Month2 — discharge from the public hospital

49. A registered nurse was responsible for Mrs A's discharge. On 13 Month2, she completed a Nursing Transfer Letter and verbally handed over Mrs A's care to a registered nurse from the rest home. The nurse told HDC:

> "Unfortunately, I cannot recall what was discussed during the handover with the registered nurse at [the rest home], given the length of time that has elapsed since the telephone call."

50. The nurse said that her usual practice was to give advice on a range of matters including the "ROM brace and cares".

51. Clinical Nurse Manager RN F also spoke to the rest home about Mrs A's care on discharge. RN F arranged for a hospital-level-care bed at the rest home, but said that she cannot recall the telephone conversation she had with the manager. She said that her usual advice would be: "[O]nly take the brace off while the patient is in bed to ensure not to flex the knee and that daily skin checks need to be observed to ensure a pressure area did not occur."

52. Waikato DHB told HDC that the rest home was not given a copy of the Nursing Transfer Letter, but was provided with a copy of the discharge summary. The rest home told HDC that it received a copy of the Nursing Transfer Letter.

53. The discharge summary recorded that on examination at Waikato DHB on 7 Month2, there was an abrasion to the right knee, and that the plan included to "continue [with] knee brace and bed rest for total 12 weeks (brace fitted on 14 [Month1])".

54. The "Key nursing interventions" outlined in the Nursing Transfer Letter include: "Right knee in ROM brace and pain management" and dry and fragile skin. There is no mention of a wound on the knee, or instructions for its care.

14 Month2 — admission to the rest home

55. RN G told HDC that on 13 Month2 she received a telephone call from RN F at Waikato DHB to discuss the knee brace management. RN G stated:

> "[Mrs A's] leg was now heavily padded with wadding under the brace, and the brace was not to be touched. Thus, it was likened to a plaster cast. [RN F's] verbal statement was clear to me. I understand this would maintain maximum stability for [Mrs A's] fracture, thus aiding optimum bony union and minimising her pain."

56. The rest home told HDC that Mrs A was admitted with a sacral sore. The rest home also said:

> "On returning from hospital admission on [14 Month2, Mrs A's] leg was heavily padded and was to be left in situ. We did not deliver any wound care to her leg as we believed she had no wound. It was only when the registered nurse was concerned about [Mrs A's] increasing pain, the physiotherapist was asked to assess and the wound was found."

57. On the Duty Handover form, RN G recorded: "[Mrs A]: For return this pm. Leave splint in situ. DO NOT REMOVE, ensure pain management optimum."

58. RN G told HDC:

> "[The rest home had] no wound assessment chart, wound plan or photograph as unaware of right leg wound due to full coverage with padding and brace, and advised this was not to be removed."

59. The Skin Integrity Assessment completed by the rest home on Mrs A's return to the rest home recorded a range of bruises and lesions on Mrs A's body. However, there is no reference to an abrasion on the right knee.

60. The brace was not removed while Mrs A was at the rest home from 14 to 28 Month2.

21 Month2 — Fracture Clinic

61. On 21 Month2, Mrs A presented at the public hospital Fracture Clinic as an outpatient. She was assessed by Dr H, an orthopaedic registrar.

62. On arrival at the Fracture Clinic, Mrs A had an X-ray, which showed that the fracture remained in a stable position. Dr H stated:

> "I cannot remember observing any skin abrasions or abnormalities, or if there was a report of concerns about the integrity of skin under the brace. I am confident if there

had been, I would have documented this in the clinic letter in accordance with my usual practice."

63. No concerns about skin abrasions were documented.

64. Dr H discussed her plan for Mrs A with a senior registrar. The Fracture Clinic note states that the registrar agreed "with the plan for gentle physiotherapy on her right ankle and to continue with bed rest in her fixed range of motion brace".

65. Dr H told HDC:

> "I cannot recall whether I removed the brace or the specific advice I gave regarding the use of the brace. I would usually remove a brace to review areas of concern/known wounds or if there were features in the patient's history or examination that increased my concern about skin integrity. Otherwise, I would try to limit removal of a brace when it is being used to stabilise a fracture."

66. Ms B told HDC that her mother was in considerable pain but that Mrs A was not offered any options or solutions for the pain.

67. Mrs A returned to the rest home.

68. The rest home told HDC that if there had been any concerns about the management of Mrs A, it would have "expected information and direction on [the] appointment feedback form".

69. The appointment feedback form from the Fracture Clinic states, "Continue in locked ROM brace, and bed rest (total 12 weeks from 14[Month1])," but does not mention a wound or wound care.

22 Month2 to 28 Month2 — ongoing care at the rest home

70. Ms I, a physiotherapist, said that following Mrs A's return from the Fracture Clinic, she planned to see Mrs A two to three times a week to undertake active bed exercises on her left leg. Mrs A was seen by a physiotherapy assistant on 20 Month2, and by Ms I on 26 Month2. Ms I said that she placed a splint on Mrs A's right foot and performed gentle range of motion exercises with the right foot.

71. On 26 Month2, Mrs A was seen by a nurse practitioner, who noted: "[Mrs A] reported to be still in pain on movement of leg and when repositioned."

72. On 28 Month2, Ms I was asked by a registered nurse to reassess Mrs A because her knee pain was increasing and she appeared to be uncomfortable. Ms I was asked to look at the brace to make sure it was sitting correctly.

73. Ms I told HDC: "As I removed the brace and padding I found a necrotic area of skin over the knee under the patella[10] around the tibial tuberosity."

74. Mrs A was immediately transferred to the public hospital, but she died the following day.

Changes by Waikato DHB

75. Waikato DHB told HDC that the process for referrals to the Pain Clinic will be reviewed, and that copies of all information provided to other healthcare facilities is now retained, including a copy of all transfer documentation.

76. Waikato DHB proposes to develop a fit-for-purpose deconditioning plan for selected patients.

Responses to provisional opinion

Ms B

77. Ms B was given an opportunity to comment on the "information gathered" section of the provisional opinion. Where relevant, her response has been incorporated above.

78. In addition, Ms B reiterated that during this period her mother was in pain and was distressed. Ms B said that seeing her mother in pain was indescribable.

Waikato DHB

79. Waikato DHB was given an opportunity to comment on the provisional opinion, as it relates to Waikato DHB. Waikato DHB advised that it accepts the outcome of the investigation and notes that the recommendations reflect the findings made in the investigation.

80. In addition, Waikato DHB stated:

> "The transfer of care needs a strong focus to ensure all staff understand the critical nature of imparting good information and linking it with care plans. Waikato DHB is committed to improving this area of care for all our patients."

The rest home

81. The rest home was given an opportunity to comment on the provisional opinion, as it relates to the rest home, and advised that it had no further comment to make.

82. HDC did not provide the new rest home owner with a copy of the provisional opinion. However, in response to the provisional decision, the new owner stated that it purchased the rest home in 2018. The new owner made a number of submissions, including that it has made changes to improve the quality of care provided to residents, and that it has received a four-year certification following an audit by the Ministry of Health. A further response was also provided by RN G.

[10] Kneecap.

Opinion: Waikato DHB — breach

Management of fracture with ROM brace

83. Mrs A was admitted to Waikato DHB on 12 Month1 with a fractured leg. Dr C, an orthopaedic surgeon, considered the surgical options and concluded that there was a low chance of providing relief, a very low chance of providing any form of function to her leg, and a significant chance of death. He and his colleagues gave the consensus opinion that Mrs A's fracture should instead be allowed to heal, immobilised with a ROM brace.

84. Independent expert advice was obtained from Dr John McKie, an orthopaedic surgeon. He advised:

> "At no stage was there any indication that would have warranted any change in the management plan.
>
> The patient was being appropriately reviewed with sequential xrays, none of which would suggest a radiological need to change the management plan because of difficulties in maintaining fracture alignment.
>
> …
>
> The fracture was minimally displaced and would certainly most appropriately be managed non operatively … I don't believe any practising orthopaedic surgeon would have recommended proceeding to a complex knee revision surgery for this lady's terminal injury."

85. I accept Dr McKie's advice. Dr C considered the surgical and non-surgical options available to manage Mrs A's fracture, and the decision to manage the fracture with a ROM brace was appropriate. In addition, I accept that the medical staff continued to review Mrs A's fracture, and that the decision to continue management with the ROM brace was appropriate.

Referral to Pain Clinic

86. Dr C told HDC that he requested an assessment for Mrs A at the Pain Clinic on multiple occasions. This directive was recorded in the clinical notes on only one occasion, and it was not recorded in the Patient Care Plan. The request was not actioned, and Mrs A was not referred to the Pain Clinic by the medical officer or any other staff member.

87. Independent expert advice was obtained from Rosalind Jackson, a registered nurse. RN Jackson advised that from a nursing perspective, Mrs A received appropriate pain medication. However, RN Jackson said that a referral to the Pain Clinic would have been appropriate. She observed:

> "[The] documentation between the progress notes and Patient Care Plan about caring for the ROM brace and skin integrity is disconnected. This is important because a multidisciplinary, co-ordinated plan promotes communication and continuity of care. Without a co-ordinated plan of care there is an increased risk of care being missed."

88. RN Jackson concluded:

> "I consider the breakdown in communication … that contributed to [Mrs A] not having an acute pain assessment as a mild deviation from accepted standard."

89. I am satisfied that Mrs A received pain medication, as prescribed. However, I am concerned that Mrs A's pain continued to be a significant issue, and that Dr C's verbal directive was not followed, and thus Mrs A was not referred to the Pain Clinic.

Discharge from Waikato DHB to the rest home on 4 Month2

90. Mrs A was discharged to the rest home with a ROM brace on her leg. The knee underneath the brace was visible and the skin was intact.

91. There is no documentation of the information that was given verbally to the rest home regarding the care of the brace and the skin beneath it.

92. Regarding the written information provided, RN D told HDC that she provided the rest home with a brochure about the ROM brace, the Patient Care Plan, and the discharge summary.

93. The brochure provided general information for people who have a ROM brace. It contains limited information about removing the brace or caring for the skin beneath the brace. The Patient Care Plan and the discharge summary contained no instructions about the management of the brace or the skin beneath it.

94. I note that Dr C left clear instructions to monitor the skin under the brace. This instruction should have been included in the Patient Care Plan, but was not. As a result, even if the Patient Care Plan had been provided to the rest home, those instructions would not have been available.

95. The rest home told HDC that it received a Nursing Transfer Letter and the discharge summary, but no brochure. The Nursing Transfer Letter contained no instructions about the care of the brace and the skin beneath it. It is not clear whether the rest home received the Patient Care Plan, but I note that it was included in the bundle of documents that the rest home provided to HDC.

96. RN Jackson advised:

> "For the discharge of 4 [Month2] … failure to clearly document and communicate transfer of care instructions for the ROM brace and care of [Mrs A's] right leg would be considered by senior nursing peers as a [moderate] departure of accepted standards."

97. Mrs A was admitted to the public hospital for the management of her fractured leg, and was discharged with a ROM brace on her leg. Waikato DHB was required to clearly document and communicate instructions for the management of the brace and the care of the skin beneath the brace, so that Mrs A would continue to receive the appropriate care.

Full and accurate notes of the verbal handover were not recorded by RN D, but I would expect the verbal instructions to mirror any written instructions. It is not clear what written instructions were given. However, in my view, it is more likely than not that the Nursing Transfer Letter, the discharge summary, and the Patient Care Plan were provided, because these documents were contained in the rest home's records. These documents did not provide any instructions on the care of the brace and the leg. I also note that the brochure, even had it been provided, did not include any detailed information on the care of Mrs A's leg. I am critical that Waikato DHB did not document the verbal handover adequately, or keep a record of the documents sent to the rest home. In addition, I am critical that the documents that did accompany Mrs A did not contain clear instructions for the care of the brace and the skin beneath it.

Discharge from Waikato DHB to the rest home on 14 Month2

98. When Mrs A was admitted to the public hospital on 7 Month2, an abrasion on her right knee was noted. An instruction was given by Dr E to remove the brace daily and review the wound and the padding. This instruction was not noted in the Patient Care Plan, and there is no documentation about whether or not this directive was carried out.

99. When Mrs A was discharged on 14 Month2, her leg was wrapped with padding, with the ROM brace positioned over it and her leg not visible. It is no longer possible to determine the condition of the abrasion on Mrs A's leg.

100. Two different nurses from Waikato DHB, on two separate occasions, discussed Mrs A's care with staff from the rest home. Neither nurse fully documented the information provided, and neither could recall the precise nature of the discussions, but they stated that the usual advice given would be that the brace should be removed while the patient was in bed, and that skin should be checked for pressure sores.

101. RN G, the Acting Clinical Nurse Manager of the rest home, stated that she has a clear recollection of the conversation regarding Mrs A's care. She said that she was told by Waikato DHB that the brace was not to be removed. This is supported by RN G's entry on the "Duty Handover" form: "Leave splint in situ. DO NOT REMOVE." Given RN G's clear recollection and the contemporaneous note, I accept that the rest home received a verbal instruction from Waikato DHB not to remove the brace.

102. The Discharge Policy requires that upon discharge from the public hospital to another healthcare facility, the discharging ward is required to supply a discharge summary, a Nursing Transfer Letter, the Patient Care Plan, clinical records, and any other document deemed relevant. In this case, it appears that the only documents provided were the discharge summary and the Nursing Transfer Letter.

103. Neither the discharge summary nor the Nursing Transfer Letter recorded that there was an abrasion beneath the brace, or contained any instructions on the care of the brace and the skin beneath it. The only reference to an abrasion is in the discharge summary, in the section that records the results of Mrs A's examination on 7 Month2.

104. RN Jackson advised:

> "For the discharge of … 14 [Month2] [the] failure to clearly document and communicate transfer of care instructions for the ROM brace and care of [Mrs A's] right leg would be considered by senior nursing peers as a [moderate] departure of accepted standards."

105. I agree with RN Jackson and note that there is a clear disconnection between the information that Waikato DHB said that it provided, and the information that the rest home said that it received. I am concerned that Waikato DHB did not document the verbal instructions provided to the rest home adequately, but I would expect that the verbal instructions would be consistent with the written instructions. I am also critical that Waikato DHB did not provide to the rest home all of the written documentation required by Waikato DHB's policy to be provided on discharge. In addition, I am critical that the documents that were provided did not adequately record the existence of an abrasion beneath the brace, or instructions for the care required for the brace and the abrasion.

Referral to Fracture Clinic at Waikato DHB on 21 Month2

106. While Mrs A was at the rest home, she attended the Fracture Clinic as an outpatient.

107. Dr H said that she cannot recall whether there had been any reports of skin abrasions, or whether she removed the brace. However, she said that if there had been any report of any concerns about the integrity of the skin beneath the brace, she would have documented this in accordance with her usual practice. No concerns about Mrs A's skin integrity were documented. Dr H also said that she would be more likely to remove a brace when it was being used to stabilise a fracture if there were any concerns about skin integrity.

108. It is unclear whether the clinicians at the Fracture Clinic were aware of the abrasion, and whether the brace was removed.

109. RN Jackson advised that failing to remove the brace at the Fracture Clinic would not have been a departure from the accepted standard, but that "it was a further lost opportunity to assess and document clearly a full skin integrity assessment from this clinic appointment at an important point in time between discharge from Waikato DHB on the 14 [Month2] and readmission on 28 [Month2]".

110. I agree. Information about the abrasion on Mrs A's knee was not communicated to Dr H at the Fracture Clinic. Had that information been available, it is likely that the brace would have been removed and the leg examined.

Deconditioning plan

111. Mrs A was on bedrest for 12 weeks from 14 Month1. Waikato DHB told HDC that it did not have a specific deconditioning plan. It said that "these considerations are generally and traditionally held within the nursing care plan".

112. RN Jackson expressed her concern about the lack of a plan to explicitly assess, implement, and evaluate care interventions to mitigate the deconditioning that Mrs A would inevitably have experienced.

113. I am concerned that sufficient planning was not undertaken while Mrs A was at Waikato DHB to mitigate deconditioning while she was in hospital and when she was discharged. I note that Waikato DHB is considering whether a separate deconditioning plan may be appropriate in this type of situation.

Conclusion

114. As detailed above, I am critical of a number of aspects of the care provided by multiple staff at Waikato DHB:

- The verbal handover instructions provided at the first and second discharge were not recorded adequately.
- On the first discharge, Waikato DHB did not clearly record the documents that were provided to the rest home, or provide instructions for the care of the brace and the skin underneath it.
- On the second discharge, Waikato DHB did not provide the rest home with all of the documents it was required to provide, pursuant to its discharge policy, and it did not note the existence of the abrasion or the care that was required for it.
- Directives given by the medical staff during the first and second admissions were not recorded in the Patient Care Plan, and were not actioned.

115. As a consequence of these actions, staff at the rest home did not have clear information about the appropriate care to be provided to Mrs A on discharge.

116. In addition, I am concerned that a deconditioning plan was not considered, and that a referral to the Pain Clinic was made but not actioned. As a result, Mrs A did not have the benefit of the Pain Clinic's expertise.

117. While individual staff hold some degree of responsibility for their failings, these deficiencies indicate a pattern of poor co-ordination and communication, within Waikato DHB and with the rest home. I am concerned that numerous staff at Waikato DHB did not record key information about Mrs A's care in the appropriate documents, and when it was recorded it was not actioned. I am critical of the poor handover information that was provided to the rest home. This information, or lack of it, may well have affected the care provided to Mrs A by subsequent healthcare providers. Accordingly, Waikato DHB failed to provide services with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: Rest home — adverse comment

First admission — 4 Month2

118. On Mrs A's first admission to the rest home, her leg was covered by a brace. The leg was visible beneath the brace, and no abrasions were observed.

119. Independent expert advice was obtained from RN Jan Grant. RN Grant reviewed the clinical documents provided by the rest home and concluded that the care provided to Mrs A was appropriate and to the accepted standard. RN Grant advised:

> "The appropriate assessments were undertaken and documented this included a Continence assessment, Pain assessment and a Skin integrity assessment. The individual assessments identified at risk issues and in my opinion appropriate actions and interventions taken. Clinical notes show that staff assisted her with daily living activities and addressed her needs in an appropriate manner. She had wounds which were dressed and treated. Assistance with meals was provided. Staff have documented her pain which appeared to be constant, and appropriate medications were administered. She was seen by a doctor two days after admission."

120. RN Grant noted that no information on the management of the brace was provided by Waikato DHB. She said that in the absence of detailed information about the care of the brace, she "would expect nursing staff to speak directly with the Waikato DHB nursing staff who cared for [Mrs A] during her admission, and to request detailed information to be faxed". RN Grant concluded that the failure to seek clarification was a mild departure from the accepted standard of care.

121. I agree. Mrs A had multiple medical conditions and was admitted with a ROM brace. The rest home was not given any instructions on the management of the brace, and I would expect the nursing staff to exercise professional judgement and seek further advice on its care.

Second admission — 14 Month2

122. At the time of her second admission to the rest home, Mrs A had developed a sore on her sacrum. Her leg was covered in padding, and the ROM brace was secured around the padding. The rest home told HDC that it had been explicitly instructed by Waikato DHB not to remove the brace.

123. RN Grant advised that the care provided on the second admission was appropriate and well documented, apart from a failure to consider the risk of further pressure area problems caused by the brace.

124. RN Grant advised:

> "[Mrs A] had a history of fragile skin and was assessed by nursing staff to be at high risk of developing pressure areas. This risk would be increased by the need for a leg brace and bed rest. She returned to [the rest home] with a grade two sacral pressure area and in my opinion, this should have alerted staff that she was at very high risk of

> developing pressure areas on any part of her body which sustained any pressure. The ROM brace would have contributed to this extreme risk and extra padding would have not been sufficient to alleviate this risk. A care plan should have been developed to minimise these risks. Regular checks should have been done to assess skin integrity. The verbal instructions entered in [Mrs A's] clinical records to not remove the brace, should have raised red flags with respect to management of pressure areas, and should have been clarified by communication with the DHB staff to ensure that an appropriate plan of care was in place."

125. RN Grant concluded that the failure to assess for pressure areas was a mild to moderate departure from accepted standards.

126. I accept my expert's advice and am concerned that a verbal instruction — not supported by any other information — was followed without question. Nursing staff are expected to assess skin integrity and to treat pressure sores. In my view, on the information available, the rest home should have been alerted to the risk of pressure sores and, as such, it had an obligation to contact Waikato DHB to clarify the instruction and to discuss the management plan.

127. RN Grant also noted that although it is appropriate for verbal instructions to be given to a rest home by a hospital, the instruction and the person who provided the instruction should be documented. She said that in Mrs A's case this was especially important, because the instruction was not supported by the discharge documents, and there was a significant change to the management of the brace.

128. RN Grant advised that "[i]t is always important to well document instruction both in terms of accuracy and for staff to follow", and that the failure to do so was a mild departure from accepted standards.

129. I note that instructions not to remove the brace were recorded in the handover sheet, but there is no other formal record of the instructions and who provided them. I share my expert's view that the documentation in this instance was not adequate.

Conclusion

130. In general, the nursing care provided to Mrs A at the rest home was appropriate. However, my expert has identified some areas in which the care provided to Mrs A was not to the accepted standard:

- On Mrs A's first admission, the rest home did not call Waikato DHB to obtain instructions on the management of the brace.
- On the second admission, the rest home should have questioned the verbal advice not to remove the ROM brace and sought clarification of that advice from Waikato DHB.
- On the second admission, the verbal instructions from Waikato DHB should have been recorded formally.

131. I am concerned that these failures suggest a lack of proactivity and critical thinking.

Recommendations

132. I recommend that Waikato DHB:

a) Provide Mrs A's family with a formal apology for the deficiencies identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding.

b) Conduct an audit of staff compliance with the discharge policy within the last three months. In particular, the audit should examine whether the correct documents have been provided on discharge, and whether the documents are accurate and complete. The results of the audit should be sent to HDC within three months of the date of this report.

c) Update HDC on the results of the investigation into the development of the deconditioning plan for selected patients, and its implementation. The update should be sent to HDC within three months of the date of this report.

d) Update HDC on the review of its process for referral to the Pain Clinic, within three months of the date of this report.

133. The rest home's assets were sold, and the contracts of all staff were terminated. Accordingly, no recommendations have been made for the rest home.

Follow-up actions

134. A copy of this report with details identifying the parties removed, except Waikato DHB and the experts who advised on this case, will be sent to the Health Quality & Safety Commission and the New Zealand Nurses Organisation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rosalind Jackson:

"Thank you for the opportunity to provide opinion to the Commissioner on this case, number C17HDC00572. I confirm that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My name is Rosalind Clare Jackson and I am a New Zealand trained Registered Nurse (NZRN comp, reg 120875) and hold a Master's Degree in Health Science. Since 2006 I have worked full time as a Nurse Leader (Anaesthesia and Surgical Services) with responsibility and accountability for operational and professional leadership to nursing in the surgical setting in a larger secondary hospital. Other training that I have completed that is relevant to the role of an Independent Advisor includes,

- **Institute for Healthcare Improvement (IHI)** — Patient Safety Programme
- **New Zealand Incident Management System** — Root Cause Analysis Training (Clinical event/investigation review)

The Commissioner is seeking my opinion on the care provided by Waikato District Health Board (DHB) and the transfer of care to [the rest home] to [Mrs A] following a fractured tibia on 12 [Month1].

1.0 Background

[Mrs A] received surgery in [2016] for a fractured femur. She presented again at the public hospital in [Month1] with a fractured tibia. The orthopaedic team treated the fracture with a leg brace. [Mrs A's daughter] has raised concerns about her mother's pain management and wound care under the brace. On 28th [Month2], at [the rest home], necrotic skin was discovered on [Mrs A's] knee. She was readmitted to [the public hospital] and passed away on 29th [Month2]. The Commissioner is seeking my comments on,

- Wound care management at [the public hospital]
- Pain management at [the public hospital]
- Information provided by Waikato DHB to [the rest home] regarding [Mrs A's] care plan and wound management.
- Any other nursing matters in this case that I consider warrants comment.

For each question I will consider and advise,

- What is the standard of care/accepted practice?
- If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?
- How would it be viewed by my peers?

- Recommendations for improvement that may help to prevent a similar occurrence in the future.

In forming my opinion on the matters requested I have reviewed the following documents provided by the Commissioner,

- Letter of complaint from [Ms B] dated […]
- Two photographs of [Mrs A's] leg, received 2 April 2017
- Waikato District Health Board response dated 9 May, 23 May and 24 July 2017
- Clinical records from Waikato District Health Board for the period [to][Month2]
- [The rest home's] response received 21 June 2017 plus their clinical records of [Mrs A's] admission to their facility.
- Discharge summary letter from Waikato DHB provided 12 September 2017 at the request of the commission.

2.0 Wound care management at [the public hospital]

After review of the supplied documentation I note the following:

2.1 The ROM (Range of Movement) brace was applied by the DHB on 13 [Month1]. Between this date and discharge to [the rest home] on 4 [Month2] there were no wound care concerns. That is, [Mrs A's] skin was intact within the brace and skin checks are regularly recorded between 16–23 [Month1]. I note reference to bruising and marking on her left leg however this appears appropriately managed. The consistency and vigilance of recording skin integrity under the ROM brace does taper off as discharge approaches. For completeness, I note the reference throughout about facial scratches and skin rash.

2.2 The Patient Care Plan Interventions document for this period, whilst completed for each day of [Mrs A's] admission, does not describe in any detail the specific care required to the skin underneath the brace. The plan of care refers to the ROM brace being in situ however is silent on the care required to maintain correct positioning of the leg and brace, skin integrity checks, or under what circumstances the brace can be removed.

2.3 [Mrs A] was readmitted to [the public hospital] on 7 [Month2] due to increased pain right leg. On assessment she had increased tenderness, redness and swelling with a mild abrasion noted below her knee under the brace. Between 7–14 [Month2], when [Mrs A] was discharged back to [the rest home], there is no further reference to the mild skin abrasion noted on admission. A pressure injury risk assessment was competed for 9th and 11th [Month2] however this was in relation to a broken area on her sacrum.

2.4 On the 10 [Month2] I note the assessment of the consultant ward round ([Dr E]). The plan of care includes 'off brace daily with wound review and padding'. This instruction is not transferred to the patient care plan which again, identifies the ROM brace and requirement to monitor skin however is not specific about the cares

required. Furthermore, between 10 and 14 [Month2] the consultant's instruction is not recorded as having regularly occurred.

2.5 **In summary**, wound care interventions delivered to [Mrs A] at Waikato DHB is appropriate and reflects an expected level of core knowledge and skill of nursing staff in an acute orthopaedic setting. However, as evidenced within 2.2–2.4, documentation between the progress notes and patient care plan about caring for the ROM brace and skin integrity is disconnected. This is important because a multidisciplinary, co-ordinated plan promotes communication and continuity of care (Health and Disability Sector Core Standard, 3.50). Without a co-ordinated plan of care there is increased risk of care being missed. In the context of [Mrs A's] **inpatient** wound care **I consider this a mild departure from accepted standards.**

3.0 Transfer of Care Information provided by Waikato DHB to [the rest home] regarding [Mrs A's] care plan and wound management.

After review of the supplied documentation I note the following:

Discharge from Waikato DHB to [the rest home] on 4 [Month2]

3.1 On the 4 [Month2] [Mrs A] was transferred to [the rest home] for hospital level care required for continuation of conservative management of her fracture. Consistent with the further information provided by Waikato DHB on 24 July 2017, the Nursing Transfer letter for this discharge does not provide any written instruction to [the rest home] in relation to care of the brace or the leg within it. Without a co-ordinated record there is increased risk to continuity and communication of care across the care team which has impacted on the transfer of care. As this is the primary reason [Mrs A] was admitted to [the rest home] for the first transfer of care I **consider this a significant departure from accepted standards in relation to transfer of care.**

3.2 Review of documentation post discharge from the DHB reinforces my assessment that the transfer of care was a significant departure. That is,

3.2.1 On the day of discharge, 4 [Month2], the nursing note refers to a handover to [the rest home] being 'done plus all paper work (done)'. Whilst this may suggest a verbal handover occurred, the extent that this included care of the ROM brace is not able to be assessed.

3.2.2 The initial documented assessment at [the rest home] is silent on the care of the ROM brace, although the requirement for pressure and skin integrity checks with full bed rest cares (no exceptions) is recorded.

3.2.3 Three days later when [Mrs A] returned to Waikato DHB on the 7 [Month2], I note the comment recorded from [her daughter], 'the brace has not been taken off to look at the leg as it is holding the leg together'. This comment is suggestive of a low level of knowledge and absence of specific instructions to care for the ROM brace and [Mrs A's] right leg.

Discharge from WDHB to [the rest home] on 14 [Month2]

3.3 Consistent with [Mrs A's] discharge from Waikato DHB on 4 [Month2], the quality of handover from [the public hospital] to [the rest home] specific to the ongoing care of the ROM brace and previously identified skin abrasion appears uncoordinated. Reflecting on point 2.4, there is no recorded evidence that an instruction had been issued to [the rest home] that the ROM brace be left undisturbed. For this second transfer of care, **I consider this a significant departure from accepted standards in relation to transfer of care.** The effect of this was an unmonitored skin abrasion with increasing risk of deterioration.

3.4 Review of documentation post discharge from the DHB reinforces my assessment that the transfer of care was a significant departure. That is,

3.4.1 As stated in 2.3, [Mrs A] was readmitted to [the public hospital] on 7 [Month2] and a mild skin abrasion below her right knee was noted. Comment has already been made that the 10 [Month2] consultant ward round instruction about the care of the ROM brace was not transferred to the patient care plan or recorded in the clinical records as having regularly occurred.

3.4.2 When [Mrs A] was transferred back to [the rest home] on 14 [Month2], I note the nursing entry that a transfer letter and handover occurred to [the rest home] however there is no evidence of a nursing transfer letter in any of the provided documentation. I note the comment from [Dr C] of 9 May 2017, that there is clear documentation by the nursing staff to the care facility of the need to regularly review [Mrs A's] skin under the brace. I can find no evidence of this in the clinical record.

3.4.3 The response letter from [the rest home] on 21 June 2017 records that on return from [the public hospital], [Mrs A's] leg was heavily padded and to be 'left insitu'. Furthermore [the rest home] assert[s] that at that time there was no wound to care or monitor for. These details appear to be at odds with the consultant instruction 4 days earlier, of the 10 [Month2] to 'off brace daily with wound review and padding'. Between 10 [Month2] and discharge to [the rest home] on 14 [Month2] there is no suggestion that this instruction had changed.

3.5 *(At the request of HDC Waikato DHB were asked to clarify whether a nursing transfer letter was completed and provided to [the rest home] on 14 [Month2]. There was no nursing transfer letter other than a medical discharge summary dated 13 [Month2]. On review of this summary letter there is no change to my findings as the summary letter is silent on the care of the ROM brace).*

4.0 Fracture Clinic Appointment 19 [Month2]

This fracture clinic appointment is important as it was an opportunity to reassess and record [Mrs A's] skin integrity under the ROM brace.

4.1 [Dr C's] response of 9 May 2017 states that deterioration of the pressure area on [Mrs A's] right leg occurred between discharge on the 14 [Month2] and

readmission to [the public hospital] on 28 [Month2]. The fracture clinic summary letter of 21 [Month2] makes no mention of [Mrs A's] skin integrity despite suggested examination of her right calf by the Registrar. I note in [Ms B's] letter that she felt she had to direct the doctor to look at her knee and brace for correct positioning however the letter is unclear about the extent that an assessment occurred. This is important because if, at this appointment, the ROM brace and padding was removed for examination this may suggest that the skin integrity was intact at that time. Alternatively, the ROM brace and padding was not removed sufficiently to examine [Mrs A's] skin.

4.2 In [Ms B's] letter of complaint she refers to a verbal instruction 'from the last x-ray' not to remove the ROM brace and cotton wool padding. As this comment coincides with the X-ray taken for the 19 [Month2] appointment, plus documented clinic feedback to [the rest home] for continuation of cares (with the addition of range of movement exercises for her right ankle) this reinforced the plan for [the rest home] to leave the ROM brace and padding undisturbed.

4.3 In summary, a lack of clear documentation on discharge about the care of the brace has already been established. Whilst this clinic appointment is not evidence of a departure from accepted standard, it was a further lost opportunity to assess and document clearly a full skin integrity assessment from this clinic appointment at an important point in time between discharge from Waikato DHB on the 14 [Month2] and readmission on 28 [Month2].

5.0 Pain management at [the public hospital]

5.1 The responses from [the public hospital] are noted. My assessment is that from a nursing perspective [Mrs A] received appropriate medication for pain as prescribed. Furthermore her level of pain is regularly recorded on the observation chart according to the pain rating scale.

5.2 I agree that a referral to the acute pain service would have been appropriate. This is because despite review of [Mrs A's] pain mediation by the team, in the context of her medical history and prolonged requirement for pain relief a broader assessment of medication options and modalities was appropriate.

5.3 A recommendation for pain team review was recorded on 20 [Month1] by the Consult liaison team however this was not followed up in subsequent assessments and is lost in the following entries in the record. In addition I note [Dr C's] response of 9 May [2017] that he repeatedly asked the junior medical team to arrange a referral to the acute pain service however this was neither documented nor acted upon. This suggests a breakdown in communication within the immediate medical and broader multidisciplinary team that meant that [Mrs A] did not have access to or gain benefit from a specialist pain team assessment.

5.4 In the response of 23 May, I support [the] recommendation to review the process of referral to the pain service.

5.5 In summary, I suggest that there may have been a loss of 'situational awareness' about [Mrs A's] pain. One definition of situational awareness is the care team maintaining the 'big picture' and thinking ahead to plan and discuss contingencies. This ongoing dialogue, which keeps members of the team up to date with what is happening and how they will respond if the situation changes, is a key factor in safety (Leonard, Graham & Bonacum, 2004). In this example, as [Mrs A's] pain continued to be a significant feature throughout her experience of conservative management of the fracture, there does not appear to have been an assessment of whether her ongoing pain was always a direct consequence of the fracture or whether it may have been related to any other cause e.g. development of a pressure injury or progressive deconditioning.

In the context of point 5.3, I consider the breakdown in communication within the medical team and broader multidisciplinary team that contributed to [Mrs A] not having an acute pain assessment as a mild deviation from accepted standard.

6.0 Any other nursing matters in this case that I consider warrants comment.

6.1 Throughout the documentation and evidence provided there is little explicit reference to a plan of care or consideration of the effects of deconditioning that [Mrs A] would experience (Jennings, 2017) as a consequence of being on bed rest for 12 weeks. Clearly the nature of injury and conservative management were known however the effects of long term immobilisation were not overtly raised until 19 [Month2] by the Physiotherapist at [the rest home] when left leg exercises were commenced and following the fracture clinic appointment of 21 [Month2], range of movement exercises for [Mrs A's] right ankle were recommended.

6.2 It was not until 25 [Month2] that [rest home] staff record plan of care interventions aimed at minimising [Mrs A's] isolation due to prolonged bedrest and confinement to her room.

6.3 In addition, prior to discharge back to [the rest home] on 14 [Month2], at WDHB [Mrs A] was being sling hoisted from bed to chair. However on 19th [Month2] the physiotherapist at [the rest home] makes a note to contact the surgeon to discuss possibility about transfer status and opportunity to be involved in activities. This is further suggestive of a breakdown in the quality of transfer information between [the public hospital] and [the rest home], as in points 3.1 and 3.3 further contributing to the findings of a departure in the standard of care relating to transfer of care.

The quality of transfer of care has already been identified as a significant departure from accepted standards. Within the plan of care, failure to explicitly assess, implement and evaluate care interventions that may mitigate the deconditioning that [Mrs A] would inevitably experience over prolonged bedrest is a moderate breakdown in accepted standards of care for an elderly person.

7.0 Summary

7.1 For the discharge of 4 [Month2] and 14 [Month2], failure to clearly document and communicate transfer of care instructions for the ROM brace and care of [Mrs

A's] right leg would be considered by senior nursing peers as a **significant departure of accepted standards.**

7.2 However, there was opportunity and obligation for [the rest home] to contact the ward to talk with the discharging registered nurse or clinical nurse manager should they have had any questions or concerns. Therefore in the context of transfer of care, **this reduces the departure from accepted standard from significant to moderate.**

7.3 In regards to the wound care interventions that occurred at Waikato DHB there is **no departure of care or accepted practice.**

7.4 Waikato DHB's commitment to review of the referral processes to their acute pain service acknowledges that on this occasion, they **accept that their care in relation to pain management fell below their desired accepted standard.**

7.5 Within the plan of care, failure to explicitly assess, implement and evaluate care interventions that may mitigate the deconditioning that [Mrs A] would inevitably experience over prolonged bedrest is a **moderate breakdown in accepted standards of care for an elderly person.**

8.0 Recommendations for improvement

8.1 [Mrs A] was discharged to a hospital level facility for non-weight bearing conservative management of her fracture. Whilst sub-acute, she still required active assessment of her care and progress. A nominated point of contact between [the rest home] and the Orthopaedic ward or specialist nurse may have bridged the knowledge gap between facilities and ensured that a 'third person' was maintaining oversight of her care.

8.2 More frequent oversight of [Mrs A] by the Ortho-Geriatric team may have resulted in a holistic plan of care that was explicit about the risks and strategies to manage inevitable deconditioning that would occur due to prolonged bed rest.

8.3 Referrals to the acute pain service are traditionally 'by invitation' from the admitting medical team. In the proposed review of process, consideration should be given to referrals being accepted from other members of the care team, not only medical staff. Alternatively, criteria could be agreed whereby the acute pain team can automatically review a patient in partnership with the admitting team, e.g. in the event of a patient being re-admitted specifically for pain management.

Rosalind Jackson
27 September 2017

References

Jennings, J. (2017). How can I help older people in hospital get home sooner and prevent deconditioning? What staff can do to help older patients return home more quickly? Nursing Older People (29), 6 Pg 21. Read More: http://journals.rcni.com/doi/10.7748/nop.29.6.21.s21

Leonard M, Graham S, Bonacum D. (2004). The human factor: the critical importance of effective teamwork and communication in providing safe care. BMJ Quality & Safety 13:i85–i90.

Standards New Zealand. (2008). Health and Disability (Core) standards, https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf"

Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from RN Jan Grant:

"I have been asked to give an opinion on the care provided to [Mrs A] by [the rest home]. I have no personal interest in the case. I previously worked in the same organisation with a staff member from [the rest home] but do not consider this a conflict of interest. My advice is based on a review of the documentation provided which included: **Background** [Mrs A] was admitted to Waikato DHB for a fracture of her right tibial plateau. She was treated conservatively with a ROM brace on her R lower limb. She was admitted to [the rest home] on the 4th [Month2]. She was readmitted to [the] DHB on the 7th [Month2] with pain and a mild abrasion to her right knee. She returned to [the rest home] on the 14th [Month2]. On the 28th [Month2], when the physiotherapist removed the brace, a large necrotic area was found around the right knee. She was readmitted to [the public hospital] and passed away the next day.

[The rest home's] response to the discharge instructions from Waikato DHB on [Mrs A's] first admission on 4th [Month2] and whether further information should have been sought for the care of the brace and underlying skin.

On discharge from Waikato DHB two information letters were provided. One was a nursing transfer letter which outlined nursing cares and was signed by a Registered Nurse. The second was a general discharge summary, not signed by, but printed by a Doctor. The nursing discharge letter indicated that [Mrs A] had multiple medical problems. It also stated that weekly follow up Xrays were required. The information pertaining to nursing cares indicated that [Mrs A] had no problem with communication, was on bedrest and completely immobile, was alert, orientated and socially appropriate and was wakeful at times. Her skin integrity was described as dry/fragile and the letter stated she would need an air pressure mattress. She had an indwelling catheter, was incontinent with respect to her bowels and wore regular wraps. Her diet was listed as a diabetic diet. She needed assistance with fluids and that fluids should be placed within reach. She also needed the assistance of one person for washing, bathing, showering and dressing. The medical discharge letter listed medical conditions and her treatment plan while at the Waikato DHB. It included a list of her medications. No information was provided on the management of the brace in the nursing transfer letter. The only information concerning the brace in the medical discharge letter was in the discharge plan where it states: '*Continue Knee Brace and bed rest for 12 weeks total (Brace fitted on 14 [Month1]'.* The clinical notes from the [the rest home] admission documentation state 'there is a brace on R leg locked at 30 deg. To be on bed rest and a follow up X Ray in one week'. No information in relation to the ROM brace was presented with the clinical notes. In my opinion, the management of a patient such as [Mrs A] in long term care, would warrant a phone call from the DHB nursing staff to the facility, and that it would otherwise be usual practice for detailed information to have been included in the discharge letter. Similarly, the DHB and [rest home] physiotherapists should have had

direct communication with respect to the management of the brace. In the event that this did not take place, then I would expect nursing staff to speak directly with the Waikato DHB nursing staff who cared for [Mrs A] during her admission, and to request detailed information to be faxed. Alternatively, clarification could be sought from the in-house Physiotherapist. A further option would be to use the internet to provide freely available information about the management of these braces.

Whether care provided to [Mrs A] on her first admission from 4 [Month2] was reasonable.

The care provided to [Mrs A] was well documented following her admission. The appropriate assessments were undertaken and documented this included a Continence assessment, Pain assessment and a Skin integrity assessment. The individual assessment identified at risk issues and in my opinion appropriate actions and interventions taken. Clinical notes show that staff assisted her with daily living activities and addressed her needs in an appropriate manner. She had wounds which were dressed and treated. Assistance with meals was provided. Staff have documented her pain which appeared to be constant, and appropriate medications were administered. She was seen by a doctor two days after admission. Her admission back to [the] DHB was appropriate when staff identified that [Mrs A] was not well. It is my opinion that care was appropriate and to an acceptable standard from her admission to [the rest home] on the 4 [Month2] until the 7 [Month2].

[The rest home] told the Health and Disability Commission that it received verbal instructions not to touch the brace or the skin underneath when [Mrs A] was readmitted on 14th [Month2]. Please advise on accepted standard of practice for when, if ever, verbal discharge instructions are appropriate and whether they should be recorded.

It is appropriate to accept verbal instructions, but the verbal instructions MUST be documented in the clinical notes. This documentation must include who gave the verbal instructions and why. However, ideally instructions should come in written form. On the Duty Handover Supplement — night shift there is a note which states: *'[Mrs A] for return this PM. Leave splint in situ, DO NOT REMOVE, ensure pain management optimum'*. This was documented on the 12 [Month2]. It does appear, in my opinion, that verbal instructions were given as demonstrated by this note. However, it is not clear who, precisely, within the DHB, gave these instructions and whether any dialogue took place to clarify a complex situation. This was a significant change to the management of the brace, and in my opinion the documentation about the phone call is minimal.

Was the care provided to [Mrs A] on her second admission from the 14 [Month2] reasonable if:

(a) [the public hospital] provided verbal instructions not to remove the brace or dressing? What is the acceptable standard of care, and was there a departure from this standard and if so, to what extent?

(b) [The public hospital] provided only written information to [the rest home]. What is the acceptable standard of care? Was there a departure from this standard and if so, to what extent?

The clinical documentation sent to [the rest home] on the 14 [Month2] included a nursing transfer letter. This letter contained information in relation to medical conditions and significant events. It noted that [Mrs A] had a brace in place and was non-weight bearing and that she had pain management issues. Under 'Services Follow Up', it stated that she was to be seen in Fracture Clinic in one week and that she was participating in a research trial. Under the 'SKIN' heading it was only ticked that her skin was dry/fragile and that she required an alternating air pressure mattress. There was no information concerning the presence or the care of her sacral pressure area. The medical discharge information listed the clinical background medical conditions the reason for admission and the management given while in hospital. Also included was a plan which stated that to continue with knee brace and bedrest for total of 12 weeks. As previously stated, there is an entry in the Duty Handover Supplement — Night Shift which states: *'[Mrs A] for return this PM. Leave splint in situ DO NOT REMOVE, ensure pain management optimum.'* This was documented on the 12 [Month2]. It is my opinion that for this to be documented then a staff member must have taken a phone call from a staff member of the DHB. This information, including the name and status of the DHB staff member, should have been documented in the clinical notes. In answering questions A and B it is my opinion that [the rest home] had a responsibility to provide cares to [Mrs A] whichever option is thought to have happened. In the event that a verbal instruction (A) was given, then that instruction should have been documented in the clinical notes. If option (B) had occurred, and only written information was provided, I am of the opinion that it should not have affected the care provided. The use of a leg brace for 12 weeks to manage a fracture such as [Mrs A] sustained, is a treatment option used in the frail elderly patient where surgery is perhaps not the best choice. Consequently, aged care facilities will be required to provide care to these patients. Having a leg brace on for 12 weeks does not prevent staff from checking and assessing skin integrity. Information on ROM Brace care may have stated that on the occasions that a brace needed to be removed, the leg would have to be immobilized in the correct position until the brace was reapplied. Staff should have done this to check skin integrity. Registered Nurses should have obtained expert assistance to carry this out, using a multidisciplinary approach. The doctor, physiotherapist, nurse practitioner and possibly a wound care specialist could have all been consulted for their input in developing a care plan to manage skin integrity, and to provide care to existing pressure areas. [Mrs A] had a history of fragile skin and was assessed by nursing staff to be at high risk of developing pressure areas. This risk would be increased by the need for a leg brace and bed rest. She returned to [the rest home] with a grade two sacral pressure area and in my opinion, this should have alerted staff that she was at very high risk of developing pressure areas on any part of her body which sustained any pressure. The ROM Brace would have contributed to this extreme risk and extra padding would have not been sufficient to alleviate this risk. A care plan should have been developed to minimise these risks. Regular checks should have been done to assess skin integrity. The verbal

instructions entered in [Mrs A's] clinical records to not remove the brace, should have raised red flags with respect to management of pressure areas, and should have been clarified by communication with the DHB staff to ensure that an appropriate plan of care was in place. It must be also noted that [Mrs A] returned to [the rest home] following an orthopaedic appointment at [the public hospital] on the 21 [Month2]. I question if the brace was removed at this time and a skin assessment undertaken at [the public hospital]. Following this visit a referral was sent to the physiotherapist to begin gentle ankle range of movement exercises. Nursing staff did inform the physiotherapist on the 28 [Month2] that [Mrs A] was in more pain. This is supported by the clinical notes. Following the removal of the brace the wound was identified and re-admission to [the public hospital] was arranged. It is my opinion that the failure to assess for pressure areas would be viewed as a mild to moderate departure from acceptable standards, taking into account the verbal order from the DHB not to remove the ROM brace.

Please indicate whether any criticisms that you make are directed at systems at [the rest home] or at specific individuals.

From the information provided, I believe that due to the verbal order not to remove the ROM Brace staff followed this instruction. They did not consider the possibility of a pressure area developing, despite the high risk factors having been recognised on a number of occasions. In my opinion, the care given to [Mrs A] was appropriate and well documented, apart from the failure to consider the risk of further pressure area problems caused by the brace.

Any other matters in this case that you consider warrant comment.

Managing patients such as [Mrs A], immobilised in a leg brace for a sustained period of time, is not an easy task. It was recognised that she was at high risk of pressure area development. A coordinated multidisciplinary approach to her management should have been undertaken. A verbal message from the DHB on 12 [Month2] to not remove the brace was documented and followed without question, even though the discharge documentation did not confirm this instruction. In recognising her high risk, I believe the staff at [the rest home] had an obligation to contact the DHB to clarify that this instruction was indeed correct and discuss the risks that would arise from such a management plan.

Jan Grant "

Further advice was provided by RN Grant:

"Yes I do consider it a mild departure from acceptable standards to both questions

1. Staff should have asked for further information from the DHB on the care of the brace if they were unsure.

   Also a mild departure in relation to not documenting verbal instructions on the second admission. It is always important to well document instruction both in terms of accuracy and for staff to follow."

Appendix C: Independent advice to the Commissioner

The following expert advice was obtained from Dr John McKie, orthopaedic surgeon:

"This report is prepared by John Stuart McKie. I completed undergraduate medical training at the University of Auckland, MB ChB, in 1984, completed orthopaedic training and was awarded FRACS in orthopaedics in 1992 and commenced my current position as Consultant Orthopaedic Surgeon at Christchurch Hospital in 1994, where I have been continuously employed in that role.

This report is based on personal review of the clinical record and the summaries of the involved practitioners. I have also independently sourced all the original x-rays that are relevant to the orthopaedic management of the case in question.

I will not repeat the detail of the chronology of care, as I believe this has been thoroughly and accurately recorded in the reports provided to you from [an orthopaedic surgeon] and [Dr C] in the documentation that you have sent me.

This lady was clearly a frail, elderly woman with multiple co-morbidities affecting many different organ systems. As well as diabetes, kidney disease, ischaemic heart and peripheral vascular disease, she also had significant orthopaedic pathologies. I note she had had a knee replacement performed in approximately 2006 and in 2012 had a total hip replacement for a femoral neck fracture on the same side. Because of her general frailty, she had moved into a rest home facility earlier in 2016, but unfortunately continued to have further falls, leading to her admission with a supracondylar periprosthetic fracture of her right femur [in 2016].

This was a difficult fracture to manage, as although the displacement of the fracture was only modest, it occurred between a hip replacement stem proximally and a knee replacement component distally in bone that was significantly osteoporotic.

The management option that the team selected to treat this with a percutaneously inserted LISS plate was the best management option for her. While this was a surgical procedure and required anaesthesia, the traumatic insult of the procedure would only be modest due to its percutaneous limited nature and would enable the patient to move around with a greater degree of freedom and comfort. The alternative to such management of a femoral fracture would involve prolonged bed rest, probably in traction in a Thomas splint, or equivalent. The chosen treatment option clearly was very satisfactory for the patient.

Unfortunately, following a further fall, the patient was re-admitted on 12 [Month1] with a new periprosthetic fracture involving her proximal tibia and fibula, closely related to the tibial component of her knee replacement.

This fracture was minimally displaced and would certainly most appropriately be managed non operatively.

I completely concur with the opinions noted by the treating Surgeons in terms of the magnitude of any surgical option to manage this problem. The only viable surgical option would be to do a knee joint replacement revision, which is several orders of magnitude greater than the percutaneous plate fixation that was able to be performed on the periprosthetic femoral fracture.

Notwithstanding the obvious challenges and [Mrs A's] deteriorating state of health during her last weeks of life, the fracture never significantly displaced from its original presenting position. At no stage was there any indication that would have warranted any change in the management plan.

The patient was being appropriately reviewed with sequential x-rays, none of which would suggest any radiographical need to change the management plan because of difficulties in maintaining fracture alignment.

Reviewing the nursing records of her admissions pertaining to the second and more recent fracture, from the time of her admission until her discharge to [the rest home], there are very clear accounts of the analgesic management that was prescribed and the nursing cares that were provided and there is a consistent theme that analgesia, in most cases OxyNorm and Paracetamol, were administered with good effect.

There is also regular annotation of the patient's daughter and/or daughter-in-law being present and being made aware of the patient's management by the nursing staff.

[Dr C] has indicated in his report the discussions he had with the family members and I can find nothing, on reviewing the notes, to in any way disagree or discredit these statements. Clearly, at the time of the writing of the letter of complaint, [Mrs A's] daughter clearly hadn't understood, accepted or remembered the meaning of the messages the medical staff had endeavoured to convey.

I note towards the end of her life, after her inpatient discharge from the hospital, pain management became more problematical and she had a number of trips back to [the public hospital]. During her final admission she was given subcutaneous Fentanyl to help manage her pain.

Clearly there were issues with the adequacy of brace fitting and its care and attention leading to the pressure area on the front of the knee. It is regrettable that this happened and may have been a factor in some of her pain. This is likely to have occurred as a combination of her developing a fixed flexion contracture of her knee and her having an ill fitting brace that wasn't checked frequently enough for the integrity of the skin underneath it. It probably also represents a surrogate marker for her underlying frailty.

This has obviously been a very upsetting episode for [Mrs A] and her family, with a frail parent having two significant orthopaedic injuries in her last three months of life and ultimately having a difficult terminal care experience. The underlying reality,

however, is that significant lower limb orthopaedic injuries sustained in the frail elderly are frequently life altering and indeed, in many cases, a life ending event.

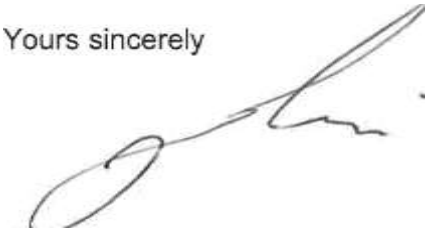
In all the worldwide studies of femoral neck (hip fractures) in the elderly, approximately 30% of those are dead within twelve months of the injury. This lady had survived a hip fracture and its treatment four years previously, but unfortunately, due to increasing frailty, combined with her co-morbidities, was having more falls, which led to the two significant noted injuries that she sustained.

While it is desirable to treat elderly patients' fractures as expeditiously as possible to get them up out of bed and prevent worsening osteoporosis and general muscle deconditioning, sometimes there is simply no alternative, even if they have undergone surgical fixation, to have a prolonged period of bed rest or bed to chair management to allow fractures to heal before they are able to be actively mobilised.

Having reviewed all the information in this case, I don't believe any practising Orthopaedic Surgeon would have recommended proceeding to a complex knee revision surgery for this lady's terminal injury. Even if a Surgeon had thought this were an appropriate course of action, it would then be questionable whether any Anaesthetist would contemplate giving an anaesthetic for a procedure which was almost certainly going to be a death sentence in its own right.

While I don't think the outcome would have been any different in this case, there are clearly things that could have been done better and the most striking example of this is the management of the patient's skin in the brace. Also, notwithstanding the detailed reports given, it would seem the message wasn't received and taken on board in the manner that [Dr C] would have hoped. I think most practitioners would probably agree that there are always times when we could do better with communication with patients, but in this case it seems he has tried quite hard. I think it is important to acknowledge that just because a doctor doesn't accept or agree with a suggestion or proposition put forward by a patient or their relative, that that suggestion has not been considered, but rather, has been discarded for very valid reasons.

Yours sincerely



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