Registered Nurse, Ms D

Registered Nurse, Ms C

Registered Nurse, Ms E

Radius Residential Care Ltd
trading as Radius St Joans Hospital

A Report by the
Deputy Health and Disability Commissioner

(Case 10HDC01286)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. When she was 38 years of age, Ms A had a stroke, and was left paralysed on her left side, with urinary incontinence, seizure activity and cognitive disruption. Two years later, she was admitted to Radius Residential Care Ltd's St Joans Hospital (St Joans Hospital). St Joans Hospital's staff included a Facility Manager, a Clinical Manager, and registered and enrolled nurses.

2. During her time at St Joans Hospital, Ms A received care and treatment related to a number of health issues, including neurological assessments related to seizure activity, behavioural and psychiatric assessments for low mood, and dietitian input for weight management.

3. In late 2009, Ms A's pressure ulcer risk was evaluated and found to be high. However, no preventative measures were taken in response to the risk. Ms A's condition began to deteriorate in 2010. She reported nausea, at times she was reluctant to eat and drink, and she was noted to have a low mood.

4. Ms A developed sacral pressure ulcers twice in 2010. The second pressure ulcer did not heal, and became infected and necrotic. Ms A was admitted to a public hospital with a high fever. She was noted to be hypotensive and in renal failure, and was provided with palliative care only. Sadly, she died of sepsis secondary to her sacral pressure ulcer.

Decision

RN C

5. Registered Nurse (RN) Ms C was the Clinical Manager at St Joans Hospital from Month1 to Month8 2010. She was responsible for clinical oversight at St Joans Hospital, and for ensuring that a quality service was provided to St Joans Hospital residents. RN C did not manage Ms A's pressure ulcer risk adequately. She failed to ensure appropriate care planning when Ms A developed a pressure ulcer in Month7 2010, and failed to ensure that there was adequate monitoring of Ms A's deteriorating health. Accordingly, she breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

RN D

6. RN D was the Clinical Manager at St Joans Hospital from Month8 2010. She was responsible for clinical oversight and for ensuring that a quality service was provided to St Joans Hospital residents. RN D did not ensure that Ms A's deteriorating condition in Month8 and Month9 2010 was adequately monitored and responded to. Accordingly, she breached Right 4(1) of the Code.

[1] Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states: "Every consumer has the right to have services provided with reasonable care and skill."

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RN E

7. RN E was the Facility Manager at St Joans Hospital from Month3 2010. She was responsible for ensuring that standards of clinical practice and service delivery were maintained, and the changing needs of residents were met. She was also responsible for managing staff and resources to ensure the delivery of safe and effective services to all residents. The Deputy Commissioner was unable to determine whether or not RN E ensured that adequate equipment was available to Ms A. In respect of the clinical care provided to Ms A, RN E was not found to have breached the Code.

Radius Residential Care Ltd (St Joans Hospital)

8. Radius Residential Care Ltd (Radius), as the owner and operator of St Joans Hospital, has ultimate responsibility to ensure that its residents receive appropriate, timely, and safe care. Radius was found to be vicariously liable for the clinical failures of its staff and, therefore, to have breached Right 4(1) of the Code. Radius was also found to have breached Right 4(1) of the Code for failing to ensure that staff were adequately oriented to, and supported in, their roles. Adverse comment was made in relation to the provision of adequate equipment, staffing, and documentation.

Dr F

9. Dr F acknowledged that he should have referred Ms A earlier for aggressive pressure ulcer treatment. He stated that he has seriously reflected on these omissions of care and has learnt from them. Adverse comment is made about Dr F's conduct.

Complaint and investigation

10. Mrs B complained to HDC about the services Radius St Joans Hospital provided to her daughter, Ms A. The following issue was identified for investigation:

> *Whether Radius Residential Care Limited, trading as Radius St Joans Hospital, provided Ms A with reasonable treatment and care in 2010.*

11. On 4 May 2012, the scope of the investigation was extended to include:

- *Whether Radius St Joans Hospital Clinical Manager, RN C, provided Ms A with reasonable treatment and care in 2010.*
- *Whether Radius St Joans Hospital Clinical Manager, RN D, provided Ms A with reasonable treatment and care in 2010.*
- *Whether Radius St Joans Hospital Facility Manager, registered nurse RN E, provided Ms A with reasonable treatment and care in 2010.*

12. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

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13. The parties directly involved in the investigation were:

Mrs B	Complainant/Ms A's mother
RN C	Provider/St Joans Hospital Clinical Manager
RN D	Provider/Registered Nurse
RN E	Provider/St Joans Hospital Facility Manager
Radius Residential, St Joans Hospital	Provider

Information was also reviewed from:

Dr F	General practitioner
Ms G	Dietitian

Also mentioned in this report:

Ms H	Ms A's welfare guardian
Dr I	Consultant psychiatrist
RN J	Registered nurse
RN K	Registered nurse
EN L	Enrolled nurse
RN M	Gerontology nurse specialist
Ms N	General manager operations
Dr O	Psychiatrist

14. Independent advice was obtained from a registered nurse with expertise in aged care, Mrs Noeline Whitehead (see Appendix A). Clinical advice was also provided by a general practitioner, Dr David Maplesden (see Appendix B).

Information gathered during investigation

Background

15. Due to an intracranial haemorrhage from a ruptured cerebral aneurysm (a stroke), Ms A became paralysed on her left side, and suffered from urinary incontinence, seizure activity and cognitive disruption.

16. After her stroke, Ms A was referred for rehabilitation and, following a number of residential placements, was transferred to Radius St Joans Hospital.

17. Ms H was appointed as Ms A's Welfare Guardian[2] under the Protection of Personal and Property Rights Act 1988.

[2] In early July 2008, a three-year order concerning Ms A's personal property (within the meaning of the Protection of Personal and Property Rights Act 1988) was made appointing the Public Trust as Ms A's Property Manager.

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18. This report is concerned with the standard of care and treatment that staff at St Joans Hospital provided to Ms A in 2010, when her condition deteriorated and she developed a necrotic pressure ulcer on her sacrum. The first section of the report discusses relevant background information, including: staffing at St Joans Hospital in 2010; St Joans Hospital policies relevant to the care and treatment that Ms A received in 2010; and the particular care and treatment provided to Ms A. The second section of the report discusses whether St Joans Hospital and its staff provided care to Ms A with reasonable care and skill, and in accordance with accepted standards.

St Joans Hospital — staffing

19. St Joans Hospital is a 65-bed residential care facility owned and operated by Radius Residential Care Ltd (Radius). Approximately half of the beds are allocated to physically disabled people younger than 65 years, such as Ms A, while the remaining beds accommodate people aged 65 years and over who have chronic illnesses.

20. At the time of these events, St Joans Hospital's staff included a Facility Manager, a Clinical Manager, registered nurses, enrolled nurses and healthcare assistants.

21. The Facility Manager job description describes the main purpose of the role as "[t]o manage staff and resources to ensure the delivery of safe and effective, quality life and health care services are provided to all residents within the facility". The Facility Manager is responsible for "[e]nsuring that standards of clinical practice and service delivery are maintained and the changing needs of residents are met" and, to that end, the role involves oversight of clinical care, and working with the Clinical Manager to implement and oversee the planning of clinical care to residents. The Facility Manager is also responsible for budgeting, staffing, staff education, maintaining relationships with associated providers, and maintaining occupancy. The Facility Manager at the time of the events under investigation was RN E.[3]

22. RN E advised HDC that although she had oversight of clinical care, the Clinical Manager was usually the first point of contact for patients, family or caregivers. RN E noted that, in fulfilling her duties, she was responsible for approximately 40 staff. She had daily meetings with the Clinical Manager, at which time she was informed of any clinical matters.

23. The Clinical Manager is employed in a leadership role to implement and oversee the planning and clinical care of all residents. The Clinical Manager is responsible for ensuring that standards of care meet the requirements of the Health and Disability Sector Standards 8134.1.2008 to 8134.3.2008, and is also responsible for staff orientation and training, identifying and documenting any clinical risk, identifying clinical quality indicators, and reviewing care delivery in relation to quality indicator outcomes. RN C was the Clinical Manager at St Joans Hospital from Month1 to

[3] RN E took on the role of Facility Manager in Month3 2010, and resigned in early 2011. RN E acknowledged and signed her job description in Month2 2010.

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Month8 2010.[4] RN D was the Clinical Manager from early Month8 2010 for seven months.[5]

24. RN C advised HDC that when she was first appointed as Clinical Manager, the Facility Manager at the time was on sick leave, and so RN C was expected to cover the Facility Manager role at the same time as orientating as Clinical Manager. RN C said that she was not formally orientated to St Joans Hospital, and did not have a performance review during her employment there. She also advised that she "received minimal support from senior management", and that at times she found it difficult to obtain the required coaching/mentoring she felt was required whilst employed at St Joans and, as a result, she found the role of Clinical Manager very stressful. RN C said that she did a daily round of all residents, at which time she observed the standard of care provision, noted any changes in a resident's condition, and discussed concerns and implemented appropriate action as required, or handed over to RNs for appropriate action.

25. RN D advised HDC that when she started at St Joans Hospital, she had one day of orientation with the Clinical Manager from another Radius Residential Care Ltd facility. RN D stated that she had to "rely strongly on the competencies and communications of the RNs".

26. General practitioner Dr F started as medical officer at St Joans Hospital in late 2009, and provided medical cover to the facility on a 24/7 basis. Dr F reviewed Ms A monthly, or as required. Dr F advised HDC that Ms A was frustrated with her increasing dependence, and she did not adhere to nursing and dietary management plans.

27. The day-to-day clinical care of Ms A was undertaken by nursing staff (including registered and enrolled nurses), who reported to the Clinical Manager and, through the Clinical Manager, to the Facility Manager.

St Joans Hospital — policies

28. St Joans Hospital provides policies and procedures for its staff to follow in the provision of care to residents. The policies and procedures relevant to this matter include pain management, wound care, and pressure ulcer guidelines.

29. The St Joans Hospital Pressure Ulcer Guidelines set out the risk factors for a resident developing pressure ulcers, risk assessment, and management of intrinsic and extrinsic risk factors. One of the intrinsic risk factors identified in the guidelines is the issue of inadequate nutritional and fluid intake, and the need for a referral to a dietitian if the patient has a pressure ulcer or is identified on the Waterlow scale as a risk.[6] The "Management of Extrinsic Factors" includes routine skin integrity checks

[4] RN C signed her job description in late 2009. She advised HDC that she was also responsible for organising multidisciplinary resident review meetings, the ordering and management of medical supplies, infection control practice, liaison with allied health professionals, and staff education.
[5] RN D signed her job description in [Month7] 2010.
[6] The Waterlow scale gives an estimated risk for the development of a pressure sore in a given patient.

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of potential sites of pressure ulceration, repositioning of "chairfast" clients hourly and "bedfast" clients two hourly, use of pressure reducing devices, and correct positioning, transferring and turning techniques. The guidelines describe five stages of pressure ulcer development, and refer staff to associated policies for pressure ulcer management.

30. The Wound Care Policy provides that all wounds "will be thoroughly assessed and care plan formulated with interventions appropriate for the specific wound and requirements of the client, including documentation of ongoing evaluation and dressing changes … on the Wound Assessment/Care Plan/Evaluation Form".

31. The Pain Management Policy describes the principles of pain assessment and management. It outlines a multidisciplinary approach to pain management and the importance of accurate ongoing assessment in the efficient and effective control of pain.

32. St Joans also has a policy relating to managing patient nutrition, which includes information for staff on types of nutritional support, hydration and the warning signs of dehydration, and how to manage food refusal.

33. The topics covered in the staff orientation/self-directed learning package include challenging behaviour, falls management, hydration and nutrition, manual handling/transferring, skin care/pressure area care, client rights, and complaints. The cover document to the package notes that by the end of the initial orientation period of three to six months, the expectation is that staff members will be able to demonstrate competence in the skills relevant to their position, and show that they have completed and understood the topics covered in the package. Staff are provided with job descriptions and orientation/self-directed learning packages.

Ms A's early care and treatment at St Joans Hospital

General health

34. During her time at St Joans Hospital, Ms A received care and treatment for a number of health issues, including neurological assessments related to reported seizure activity, behavioural therapist and psychiatric assessments for low mood, orthopaedic follow-up for pain in her left shoulder, and general practitioner and general surgical input for epigastric pain and vomiting. According to Ms A's medical records, on occasion she was depressed and "not enjoying life".

Weight management

35. Ms A also received dietitian input for weight management. In late 2007, Ms A's weight was 158kg, and she was referred to dietitian Ms G for weight loss advice. Ms G commenced Ms A on the Optifast weight loss programme, with an initial goal weight of 120kg. Ms G continued to review Ms A every one to three months.

36. In early 2009, Ms G reviewed Ms A and noted that her weight had reduced to 130kg. Ms G recorded that Ms A was depressed and expressing suicidal thoughts. She advised the care staff of the importance of encouraging Ms A with the meal plans, and noted that the aim of the programme was to continue with steady weight loss to a goal

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weight of 120kg. Ms G advised HDC that, for her assessments, she relied on the nurses and caregivers at St Joans Hospital accurately recording Ms A's fluid and weight charts. However, when she received questionable weight readings later in 2009, she questioned the accuracy of St Joans Hospital's scales or its weighing process.[7]

Assessment of pressure ulcer risk

37. Late in 2009, Ms A's pressure ulcer risk was assessed using the Waterlow scale assessment tool, and her risk was found to be 28. A Waterlow score of 10 or more requires preventative pressure relieving measures to be taken. No preventative measures were taken at that time.

Ms A's care and treatment in 2010

General deterioration

38. RN C advised HDC that in Month4 2010, there was a general deterioration in Ms A's condition.

39. On 1 Month4 2010, staff reported to Dr F that Ms A was exhibiting low mood. Dr F spoke to Ms A, and she denied that her mood had changed or that she had any physical problems other than nausea. Dr F noted at that time that Ms A's visitors suggested to St Joans staff that she may have had another stroke, as her right-sided coordination had decreased. Dr F was unsure whether Ms A's condition was attributable to a further cerebral event or whether it was behavioural.[8]

40. On Saturday 8 Month4 2010, Dr F was telephoned by St Joans staff seeking advice on the management of Ms A's reluctance to eat and drink. RN C noted that, at that time, Ms A would refuse meals, and eat only breakfast and small snacks throughout the day. Dr F ordered, by fax, the administration of subcutaneous fluids to Ms A. RN C said that Ms A was given subcutaneous fluids for 48 hours, and was then provided with Fortisip.[9]

41. Mrs B advised HDC that after Month4 2010, Ms A's meals were placed on her bedside table at the foot of her bed and no one was helping her to eat, and staff incorrectly reported that as Ms A refusing to eat.

42. Dr F telephoned St Joans three days later to check Ms A's status, and was advised that she was taking oral fluids again and was hydrated, and that a visit was not necessary.

[7] Ms G advised HDC, "There had been an occasion in [mid] 2009 when the scales had reported a weight loss of 29kg in three months and then the next month she was 23kg heavier again, which presented me with issues as to how accurate the scales were, or how well weights and weighing were carried out."

[8] In late 2009, St Joans staff reported to Dr F that Ms A had been observed to have a short-lived episode of right-sided facial droop. Dr F was aware of Ms A's medical history (the intracranial haemorrhage) and stated, "If this is transient ischaemic attack, aspirin or warfarin are not a good idea". He noted that Ms A did not have any atrial fibrillation and that her blood pressure was 129/80mm/Hg (normal blood pressure is considered to be 120/70mmHg (millimetres of mercury)).

[9] A nutritional supplement.

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Dr F contacted Ms A's Welfare Guardian, Ms H, and Mrs B to discuss Ms A's mental state, and informed them that she was eating poorly, was very morose, and was not co-operating with staff interventions. He noted in the clinical records that Ms A's "[p]oor co-operation made evaluation very difficult". He queried whether Ms A was depressed or whether she had had a mild stroke. He also noted that she had "a cholelithiasis[10] or gall bladder abscess", and arranged blood tests and a prescription of Augmentin.

43. On 12 Month4 2010, Dr F sent referrals to the District Health Board's Neurology and Neurobehavioural clinics requesting an assessment of Ms A's status. A neurologist wrote to Dr F on 26 Month4 advising that it would be preferable for the Neurobehavioural Team to see Ms A first and, if necessary, request a CT scan.

44. On 17 Month5 2010, Dr I, a consultant psychiatrist at the DHB Community Neurobehavioural Service, wrote to Dr F to report his assessment of Ms A. Dr I stated that he believed that Ms A had had a second neurological insult, but there were no clear changes of mood or other behavioural difficulties. He noted that it would be useful to check Ms A's anticonvulsant levels, and that the focus should be on aggressive physiotherapy and speech and language therapy for rehabilitation of her existing neurological deficits. Dr I considered that Ms A's reduced food and fluid intake most likely reflected an underlying neurological cause.

45. RN C advised HDC that, in Month4 2010, when the deterioration in Ms A's condition was noted, she had discussions with care staff and other health professionals involved in Ms A's care, to set objectives and put in place interventions to improve her situation. RN C advised HDC that Ms A was moved to a bigger and more suitable room, and

> "commenced on a repositioning programme including documentation on a turn chart as per organisational policy/procedure. Fortisip was introduced following discussion with her doctor as there was concern re her poor nutritional intake … [Ms A] complained of a painful sacral area at this time. [Ms A] was using a Roho cushion in her chair and a request was made to the Facility Manager to access a suitable Alternating Air Mattress as there were none available on site … Staff were informed to continue with the regular repositioning programme in the meantime. [Ms A] was encouraged to spend time on bed rest in the afternoons when there were no activities she wished to attend."

46. Although copies of all relevant clinical records were requested, HDC was not provided with copies of turn charts for Ms A.

47. In her response to the provisional opinion, RN C stated that the need for an alternating air mattress was identified to management in Month4 or Month5 2010.

[10] Gall bladder stones.

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48. RN E has no recollection of RN C requesting an alternating air mattress for Ms A in Month4 2010, and believes that RN C is mistaken in her recollection. RN E noted that she purchased several pressure relieving devices for "at risk" patients (see below), and that when the alternating air mattress was requested for Ms A, it was obtained without delay.

49. Ms G reassessed Ms A on 5 Month5 2010. At that time, Ms A weighed 95kg.[11] Ms G advised HDC that Ms A appeared to be well, and that she reported that she was eating well. However, staff told Ms G that there were occasions when Ms A refused her meals, which they attributed to behavioural issues. Ms G discontinued Ms A's Fortisip, and instructed St Joans Hospital staff that Ms A was to remain on a low fat diet. Ms G said that she gave the kitchen staff some strategies to manage Ms A's meal refusal, including instructions to offer Ms A a trim milk smoothie. Ms G stated:

> "At that time I had reinforced the importance of regular weights to monitor progress. Her symptoms at this point did not lead to a need for Fortisip supplement. The low fat diet which she was currently on, was not an extremely low calorie diet and so did not pose a threat to protein or micronutrient intake."

50. RN C advised HDC that a weighing programme was in place, but Ms A would refuse to be weighed.

51. On 6 Month5 2010, staff recorded that Ms A had a pressure sore on her sacrum, which was 0.5cm wide and 0.5cm long and was classified as "Grade 1".[12] A Wound Assessment and Care Plan chart was commenced, which recorded that a Hydrocoll dressing was applied and advice was given to change the dressing as necessary. The pressure sore was reviewed, cleansed, and re-dressed on 7 Month5 2010.

52. On 9 Month5 2010, RN C instructed staff to commence a fluid balance chart and to ensure that Ms A was provided with adequate fluids. RN C also instructed the registered nurse on duty to monitor Ms A's intake and check the fluid balance chart.

53. On 19 Month5 2010, the Wound Assessment and Care Plan records that Ms A's pressure sore had "completely healed".

54. On 20 Month5 2010, RN J noted on Ms A's Care Plan that staff should weigh Ms A monthly and record her weight,[13] "encourage [Ms A] to finish her meals", and offer her alternatives if she refused her meals. It was noted that Ms A was "very strict" in adhering to her diet. RN J also noted that Ms A's skin condition was to be assessed daily to prevent the development of any pressure sores, and that she should be nursed side to side.

[11] In early 2009, Ms A weighed 130kg. In Month1 2010, Ms A's weight was recorded as 101kg.
[12] According to the Pressure Ulcer Guideline, a "stage 1" ulcer is "an observable pressure related alteration of intact skin … the ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues".
[13] The plan noted that weighing Ms A when she was supported only by a hoist was difficult because of her disability.

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55. On 25 Month5 2010, a Wound Assessment and Care Plan was commenced for wounds on Ms A's sacrum and inner thigh.

56. In a further update to Ms A's Care Plan on 27 Month5 2010, RN J referred to the need to "prevent further developing an area (reddened) on lower sacrum".

57. On 31 Month5 2010, RN C noted in the Care Plan that the Roho cushion was to be in place when Ms A was positioned in her wheelchair or recliner chair.

58. There were entries in the progress notes or on the Wound Review Plan on 3, 4, 6, 7 and 8 Month6 2010. On 11 Month6, RN K noted that there was no broken area on Ms A's sacrum and that it had "[h]ealed completely".

59. On 17 Month6 2010, a multidisciplinary review meeting was held. The notes from this meeting refer to Ms A having a "small sacral pressure area", and state that she is now using a Regency chair.[14]

60. On 18 Month6 2010, RN K documented in the progress notes that Ms A's sacrum was intact.

61. In Month6 and Month7 2010, Dr F was asked to review a recurrent rash in Ms A's left armpit. Dr F reviewed Ms A and arranged a swab and treatment for the rash. Dr F also noted that Ms A was reporting pain in her left foot, but his physical examination of her foot did not find any evidence of fracture or trauma. Dr F considered that Ms A foot pain was "consistent with central sensitivity".

Pressure ulcer development

62. On 2 Month7 2010, RN K completed an Incident/Accident report noting that Ms A had complained of buttock pain while sitting in her chair that morning. When Ms A was returned to bed, staff observed that she had an area of broken skin on her sacrum, which was "small in size" measuring half an inch by half an inch, was "raw", and "round in shape [with] uneven edges". RN K recorded that the wound was cleansed with water, and a dressing was applied. She noted that Ms A had not been sitting on her Roho cushion because it had been soiled and washed on 30 Month6 and "left to dry in bathroom". RN K noted that the Roho cushion had been "reapplied", and that staff should ensure that it was "inflated accordingly" and on the chair at all times. On 6 Month7, RN C signed off the Accident/Incident form, adding, "Night staff are to position Ms A on her Roho cushion on the blue chair".[15]

63. RN C advised HDC that it was considered that the further breakdown in Ms A's skin over her sacral area in Month7 2010 was caused by frequent bowel motions. RN C stated that the need for good hygiene was highlighted in the progress notes, to remind

[14] A type of chair that offers postural support, positioning and pressure care.
[15] HDC was provided with no Wound Assessment and Care Plan documents for the wound identified on 2 Month7 2010. RN C has questioned the lack of these for Month7, as she recalls that they were in place.

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care staff to change Ms A's incontinence products when soiled, and to make sure that her skin was washed and dried thoroughly.

64. On 5 Month7 2010, the progress notes record that Ms A's sacrum was "just about healed", but that she had an abrasion and a rash in her groin. Dr F was advised, and he checked Ms A's groin that day. He advised that the area was not infected, and suggested that care staff apply barrier cream to the area. Dr F recorded this examination in his medical notes.

65. Ms A's wounds were dressed by the enrolled or registered nurses, and the wound charts were completed by the nurse dressing the wound at the time.

66. On 8 Month7 2010, RN J updated Ms A's Care Plan to include the use of an alternating air mattress.[16]

67. RN C advised HDC that she checked the positioning of at-risk residents daily, including Ms A, and that she or the physiotherapist would check the pressure of both the air mattress and Roho cushion. On 10 Month7 2010, an entry in the progress notes records that the pressure area "appears to be healing". However, according to an entry for the afternoon shift of 19 Month7, the pressure area was "not improving".

68. On 26 Month7 2010, Enrolled Nurse (EN) EN L's entry in the progress notes referred to changing a dressing but did not specify whether this was on Ms A's sacrum.

69. On 27 Month7 2010, RN C amended the Care Plan, noting that Ms A had lost several kilograms "over the past few months". Although RN C recorded that this was not a concern, as it had been recommended that Ms A lose weight, RN C instructed care staff that Ms A's meals were to be made "more tempting".

70. On 28 Month7 2010, Ms G reviewed Ms A, noting that her weight had not been recorded since Month5 2010. Ms G recorded that Ms A appeared to have deteriorated and lost weight. Ms G observed Ms A drinking water, and noted that she held the water in her mouth for several seconds before swallowing. Ms G recommended to staff that Ms A continue to be weighed monthly, and that if her ability to swallow deteriorated then she was to be referred to a speech language specialist. Ms G asked the caregiving staff to assist Ms A with her meals. A note was made in the doctor's diary to refer Ms A to the speech and language therapist, although it does not appear that the referral was made. For the main part, thereafter, care staff recorded Ms A's food and fluid intake in the progress notes.

71. There is no record of Ms A being weighed in Month6 or Month7 2010. RN C advised HDC that staff were unable to weigh Ms A at that time as the charger for the chair scales had broken and the ordered replacement had not arrived.

[16] RN C advised HDC that the delay in including the air mattress in Ms A's Care Plan was because there was no suitable air mattress available at St Joans Hospital prior to that date. As noted in paragraph 48, RN E believes that RN C is mistaken in her assertion that a mattress had been requested in Month4 2010.

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72. In response to the provisional opinion, RN E stated that if she became aware of faulty equipment, or when faults were brought to her attention by staff, as Facility Manager she had a responsibility to ensure that the equipment was fixed and, if there was a missing charger, this was not something to be left unattended. However, RN E said that she was not previously aware that the weighing scales were out of action for two months, and finds it inconceivable that this was the case. RN E stated that in the unlikely event that this was so, given that all clinical staff were aware of the importance of weighing "at risk" patients, she ought to have been made aware of this, but was not.

73. RN E stated that she was not aware that Ms A was not being properly weighed, or that once the air mattress was supplied, it was not set appropriately.

74. RN C stated that while the scales were out of order, she used her clinical experience to judge the pressure in Ms A's pressure relieving mattress, by inserting her hand under Ms A's buttocks to gauge the amount of air present in the mattress. RN C also used this method to test the pressure in Ms A's Roho cushion. RN C said that testing that pressure relieving devices were correctly set was part of her daily routine, and that she would often have to retest the pressures, when care staff had not checked the pressure or had inadvertently changed it.

75. On 1 Month8 2010, EN L recorded in the progress notes that Opsite spray was applied to Ms A's sacral pressure area.

76. On 2 Month8 2010, the physiotherapist recorded in the progress notes that a cover for Ms A's Roho cushion had been located and she had been repositioned on the cushion to prevent further deterioration of her sacral area.[17] The physiotherapist ordered that Ms A be repositioned every two hours. RN C instructed staff, by recording in the progress notes: "Roho cushion to be on chair before [Ms A] is placed in it."

77. RN C noted in the progress notes on 2 Month8 2010:

> "1600, [Ms A's] behaviour will continue to be somewhat inappropriate due to her increasing deterioration in her general condition. Staff are to learn how to manage this challenging behaviour and to be patient with [Ms A]. She is to be fed if she cannot manage on her own."

78. Mrs B said that throughout Month8 2010 she expressed her concern to staff about Ms A's ulcer, which she recalls was "inflamed, weeping, black and very smelly".

79. There are references in the progress notes to dressings on Ms A's sacrum being changed on 4, 8, 9, and 11 Month8 2010.

80. RN C left the employ of St Joans Hospital on 6 Month8 2010, and RN D was the Clinical Manager at St Joans Hospital from that time.

[17] RN C advised HDC that she had asked the physiotherapist to obtain a cover, so that if the cushion became soiled (as occurred at the end of Month6) the cover, rather than the cushion, could be washed.

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81. On 14 Month8 2010, RN J recorded in the Skin Integrity section of Ms A's Care Plan: "Identified pressure sore on sacral area (grade 2; width 2.5cm, Depth 2cm length 2cm)".[18] The ulcer was also described as being slightly necrotic. RN J noted that pain medication had been prescribed and the Clinical Manager and Facility Manager were informed. Care staff were instructed that Ms A should be monitored strictly, and that she was to be reviewed by the doctor. RN J also noted: "Roho mattress/air mattress made available. Configure air mattress to right setting as to her current weight please."

82. RN E advised HDC that Ms A's pressure sore was brought to her attention that day, and she instructed the Clinical Manager (at that time, RN D) to contact the DHB wound specialist and the dietitian.

83. That day, EN L started a Wound Assessment and Care Plan (the wound plan). The wound plan described the appearance of the wound, specified the type and frequency of dressings to be applied, and provided for daily review recording.

84. Dr F advised that he was told about the pressure area on Ms A's sacral area, but he did not see the area until 16 Month8 2010, because of the difficulty of moving Ms A and the need to co-ordinate his visit with the availability of the staff needed to position her. Dr F recorded in his clinical records that the pressure area was not infected, and he described it as "sloughy". Dr F checked Ms A's pressure ulcer again on 26 Month8, 2 Month9, and 9 Month9. He stated:

> "This also involved co-ordination with staff to achieve because of her obesity and immobility and the use of long-term dressings on the area. I was told that [Ms A] would not cooperate with the staffs' attempts to regularly reposition her to take the pressure off the sacral pressure area. She was also eating and drinking poorly, needing to be fed and often apparently declining to eat. Because of this we arranged a dietetic assessment to enable us to use supplementation to increase her protein intake in order to help in ulcer healing."

85. Dr F advised HDC that, on 23 Month8 2010, he adjusted Ms A's pain relief. She had been taking codeine 30mg twice daily and he "adjusted it upwards by the same amount". Dr F noted that Ms A's pain was mainly when she was moved. He said that it was difficult to determine the extent of her pain, because it was difficult to get a consistent history from her. He also stated, "Given her poor eating and drinking, and her poor compliance with her cares I was reluctant to begin any use of morphine which could well lead to drowsiness and even less co-operation." Dr F recorded in his medical notes that Ms A was also referred to the Community Wound Care Specialist for an opinion and advice.

[18] According to the Pressure Ulcer Guideline, a "stage 2" ulcer involves "[p]artial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater".

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86. On 24 Month8 2010, RN M, a DHB Gerontology Nurse Specialist, reviewed Ms A at the request of RN D. RN M recorded that Ms A's sacral pressure sore was 2cm deep, 3x3cm wide, and "sloughy". RN M documented a plan to apply Solosite/adaptic and a dry dressing, and advised RN D to do a daily dressing. RN M noted that Ms A's air mattress was set at 85kg, and it was changed to 65kg in accordance with Ms A's weight at the time. RN M told HDC that she advised staff to be vigilant in checking that the air mattress pressure was adjusted correctly, and emphasised to RN D the need to monitor and encourage Ms A's nutritional intake, as nutrition has a "huge" impact on wound healing. RN M instructed staff to contact her if they required advice about Ms A's wound dressings.

87. At 8am on 25 Month8 2010, care staff observed that Ms A was "sweaty", vague and slow to respond. Ms A reported that her pressure area was painful, and she was given codeine for the pain. There is no record that her temperature was taken at that time. However, her blood pressure was recorded at 92/43mmHg[19] and her pulse at 68 beats per minute (bpm).[20] Staff reported the observations to RN D, who advised them to observe Ms A. At midday, Ms A's carer observed her to have a "? small turn". Mrs B was contacted regarding her daughter's condition.

88. At 1.30pm, Ms A's temperature was checked and recorded as 36.1°C. The progress notes that afternoon note that Ms A was "a bit perky and bright".

89. On 27 Month8 2010, the shift RN noted that Ms A's condition was "very frail".

90. Ms G reviewed Ms A again on 31 Month8 2010, and recorded that although Ms A's weight was noted to be stable, Ms A had visibly lost weight.

91. Ms G noted that Ms A had a pressure area on her sacrum, and recommended a high protein diet and Fortisip. Ms G encouraged staff to "be positive when feeding [Ms A]", to maintain monthly weighs, and to keep a food chart. Ms G also asked that Ms A's GP order a complete blood count, including liver and proteins, and that an application be sent for Fortisip.

92. Ms G advised HDC:

> "My last two visits to see [Ms A] showed a marked deterioration, at which time I requested weights (which again had not been well completed) and bloods to confirm a protein deficiency. An application was then sent for Fortisip due to a pressure area, which had developed. [Ms A's] ongoing behavioural issues did complicate treatment, so at times it was difficult to assess whether she was physically unwell or 'choosing' to withhold food intake."

93. On 1 Month9 2010, Ms A's temperature was recorded on the TPR (Temperature, Pulse, Respiration) chart as 38.8°C, and annotated, "Commenced antibiotics". Ms A's pressure ulcer was noted to be inflamed, and RN D and Dr F were informed. It was

[19] Normal adult blood pressure is about 120/80mmHg.
[20] A normal resting adult pulse rate is between 60 and 100bpm.

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noted in the progress notes that although Ms A ate her meals when fed, she refused to take Fortisip.

94. On 2 Month9 2010, Dr F viewed Ms A's sacral wound. The nursing progress notes record that Dr F found the wound to be "slightly inflamed only". Dr F prescribed Ms A the antibiotic flucloxacillin, for what he described to HDC as "a local infection in the surrounding tissue of the pressure sore". Although Dr F prescribed the antibiotic on 2 Month9, it appears that the first dose was not given until 7am on 3 Month9. This means that there was a delay of more than 12 hours between Dr F charting the medication, and the antibiotic being administered to Ms A.

95. RN E stated that the system at St Joans Hospital for medication management required that the RN on duty fax the pharmacist the prescription, and that the medicine be delivered promptly. Ms A was given the antibiotic at 7am on 3 Month9 2010, which indicates that it had arrived at St Joans on 2 Month9, and that this part of the system had worked. The medication container would have been labelled with the time and date the antibiotic was to be given, ie, 7am, 3pm and 8pm. RN E stated that the facts show that a system was in place, but the delay in the administration of the antibiotic likely resulted from an oversight by the RN on duty on 2 Month9 to administer the antibiotic at 8pm, as charted.

96. At 2.50pm on 3 Month9 2010, Ms A's temperature was found to be elevated at 38.5°C. The temperature was recorded in the progress notes but not on the TPR chart. Ms A was given paracetamol and her prescribed antibiotics, and also a cool sponge to reduce her temperature. Ms A refused to take the offered Fortisip. A message was left for Mrs B, advising her of Ms A's condition.

97. At 3.30pm on 3 Month9 2010, Ms A's temperature was checked and recorded on the TPR chart as 38.5°C. At 9pm, Ms A's temperature was again checked and recorded on the chart as 36.6°C. Ms A's other vital signs were within normal margins.

98. On 4 Month9 2010, the TPR chart records Ms A's temperature as stable at 36.8°C. No further temperature recordings were entered onto Ms A's TPR chart until 12 Month9.

99. RN E advised HDC that, on 5 Month9 2010:

> "… I had noted on my morning rounds that [Ms A's] appearance was not that of a resident who had received personal cares, neither was her bed linen fresh. It was my belief that [Ms A] enjoyed getting up early in the morning and resting after lunch in her room. In view of this the previous Clinical Manager had arranged for the night staff to tend to [Ms A] before the day shift came on duty. On this particular day I don't believe this happened. I addressed the morning nurse in charge and instructed her to ensure [Ms A] was washed, her teeth cleaned and her linen changed.
>
> In my daily catch up with the Clinical Manager it was discussed [that] the night registered nurse would delegate the duty to a specific nurse and the Clinical

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> Manager would follow up on this. I would be informed if this wasn't happening. There were no further incidents."

100. EN L re-dressed Ms A's sacral ulcer on 5 Month9 2010, and recorded in the progress notes that the tissue surrounding the ulcer was necrotic.

101. On 6 Month9 2010, EN L recorded in the progress notes that RN E was present during the change of Ms A's sacral dressing to assess the condition of the ulcer. EN L recorded that the necrotic area was "getting better".

102. RN E advised HDC that she relied on feedback from the Clinical Manager to be updated on patient care, and she was not made aware that Ms A's ulcer was not resolving. RN E advised that when she was made aware, at the beginning of Month9 2010, she asked to see the wound and then asked the Clinical Manager to contact the wound care nurse specialist from the DHB.

103. At 10.30am on 7 Month9 2010, RN M was contacted for advice about Ms A's pressure ulcer. RN M stated that she would visit on 9 Month9 to reassess the ulcer, and advised staff on alternative dressing regimens in the meantime. Mrs B was advised about Ms A's condition, and Mrs B requested a meeting with staff to discuss this.

104. On 8 Month9 2010, staff reported that Ms A's condition appeared to have improved. She was more alert and responsive, and was eating and drinking well. However, the condition of her ulcer was observed to be rapidly deteriorating, with increased necrosis and inflammation.

105. RN M advised HDC that she reviewed Ms A's pressure wound on 9 Month9 2010 and changed the wound dressing products. RN M noted that a cavity and necrosis had developed. She advised the St Joans staff to use Intrasite Conformable to lift off the dead tissue and assist healing. RN M stated:

> "At my visit [Ms A] was conversing well; and there was no indication of her not eating or being nauseated from the staff or [Ms A] [sic]. She was directing her cares at my visit as she was being attended to by caregivers for her personal cares. Conformable does not need to be changed daily however, I did advise to review the need to change daily and to contact me as needed. It was clearly indicated to me that the plan was to get Intrasite Conformable that same day and change the wound dressing to the new regime/care plan and that [RN D] was happy to do this."

106. RN M's recommendation to use Intrasite Conformable for Ms A was not implemented, as it appears that the products required were not available.

107. RN E advised that on 10 Month9 2010, she recorded in the progress notes, "New dressing [ordered] by [RN J] — will be here hopefully Monday." RN E stated that attempts had been made to source the wound products that RN M recommended. However, the Intrasite Conformable was a specialised product, which the supplier did

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not have in stock, and hence was not immediately available. RN E recalls instructing RN J to contact RN M to ask about an alternative dressing to use in the meantime.

108. Dr F also reviewed Ms A's pressure sore on 9 Month9 2010. While he recorded in his clinical records that the pressure area was "not improving", he did not consider that she required urgent admission for surgical debridement or for her infection, which he described in his response to HDC as being a "local infection" at that time. However, in his clinical records, he recorded "no infection".

109. On 10 Month9 2010, the results of the blood tests requested by Ms G on 31 Month8 were reported, and indicated that Ms A's haemoglobin and serum protein levels were below normal.

Request for admission

110. Ms A's Welfare Guardian, Ms H, advised HDC that, at that time, she repeatedly asked for Ms A to be admitted to hospital, but was told that Ms A was improving.

111. RN E recorded in the progress notes that she met with Ms H in the afternoon of 10 Month9 2010. RN E recorded in the progress notes that she talked to Ms H about Ms A's condition and the wound management plan, and that Ms H was happy with progress. RN E does not recall Ms H suggesting that Ms A should be admitted to hospital. RN E stated that she would have been "careful not to reject [such a suggestion] lightly and would have followed up with the doctor and noted the point …"

112. Mrs B stated:

> "[Ms A's] final months spent at St Joans were an absolute nightmare and her daily care hovered between extremely poor and non existent. … [My partner and I] had been trying to get her into hospital for at least four weeks previous to her admittance … and even went to see our own GP … and asked her to intervene by visiting [Ms A] at St Joans and letting us know how her general health was. [Our GP] told us that it was not her field. … We also had a meeting with the Facility Manager … on the 10th [Month9], she was going on leave overseas that day. [We] demanded that if [Ms A's] condition deteriorated or changed at all she was to be admitted to Hospital immediately."

113. Dr F advised HDC that when he last saw Ms A's pressure wound on 9 Month9 2010, he believed that it did not warrant her urgent admission to hospital. He stated:

> "At the time of the request from the family to admit [Ms A] to [hospital], the primary reason for doing so would have been her lack of cooperation with eating, drinking, and turning. At the time I understood their quite reasonable distress at [Ms A's] problems, which extended well beyond her pressure ulcer, and would readily have complied with that request had I felt she would have been accepted by the General Medical/Surgical registrars on call. However, I did not feel she would have gained admission at that time, and therefore declined to attempt to do

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what I considered would be futile. In hindsight it is regrettable the family and I did not have further contacts about their ongoing concerns."

Deterioration

114. At 7am on 12 Month9 2010, the caregivers reported to the duty RN that Ms A was complaining of feeling hot. The RN found that Ms A's temperature was elevated at 40.8°C, and her blood pressure was low at 90/60mmHg. Her heart rate of 78bpm and respiration rate of 20 breaths per minute were within normal limits. This information was recorded on Ms A's TPR chart. Ms A was responsive to pain but unable to follow commands. She was given paracetamol, and Dr F was advised of her condition.

115. Dr F stated that the St Joans Hospital duty RN telephoned him on the morning of 12 Month9 2010 to report that Ms A was unwell with a temperature, and he recommended that Ms A be admitted immediately to a public hospital.

116. The RN telephoned for an ambulance and contacted Mrs B to advise her of Ms A's condition and Dr F's decision to admit her to hospital.

Public Hospital

117. Ms A was admitted to the public hospital. A Palliative Care Specialist recorded Ms A's admission, noting:

"Prior to admission [Ms A] had developed a sacral pressure sore which became increasingly worse despite antibiotics. She was admitted on 12 [Month9] with a high fever, hypotensive and in renal failure. Initially proactive treatment was commenced, but on reviewing her functioning, personal wishes and co-morbidities the team and the family agreed that [Ms A] should not be for proactive treatment."

118. Mrs B advised HDC that the registrar on duty at the hospital advised her on 12 Month9 2010 that Ms A's organs were shutting down because of her ulcer, and that Ms A would not survive the multiple operations it would take to debride the ulcer.

119. Ms A was provided with palliative care. Her condition deteriorated further, and she died two days later. Her death certificate recorded that the cause of her death was sepsis secondary to a sacral pressure sore.

Other information

St Joans Hospital

120. St Joans Hospital advised HDC:

"Review of multidisciplinary progress notes demonstrate a good level of rapport existed between [Ms A] and the nursing and allied care staff. Individualized comprehensive care planning and evaluation is evident and involves a multidisciplinary approach to [Ms A's] care validated by the multiple entries in her records of physiotherapist, podiatrist and dietician as required, in addition to nursing entries and multiple referrals to external healthcare providers and services as indicated. …

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> Due to immobility and prolonged periods spent in her wheelchair, [Ms A] required regular pressure area relief. [Ms A] experienced several breaches in skin integrity of the sacral area in the 12 months preceding her death. Regular pressure area cares and pressure relieving equipment which included a roho cushion, pressure relieving mattress and regency chair were utilized as preventative measures and evidenced in the clinical file. …
>
> Upon reflection of the nursing care provided to [Ms A], we do not believe that the staff of Radius St Joans Hospital nor [Dr F] have failed in their duty of care to [Ms A] in relation to her care provision. …
>
> In respect of comments made around the commencement of antibiotic treatment, we refer to [Dr F's] response, and advise that this was not commenced earlier as [Dr F] did not feel that the wound was infected. We also refer to [Dr F's] response around the issue of pain relief and believe that the regular codeine that [Ms A] was prescribed and administered was appropriate to manage her pain and there is no validation within the progress notes to the contrary, indeed [Ms A] refused pain relief on occasions. …
>
> In conclusion, we can identify and empathise with the grief and anxiety that family members and friends are currently experiencing as a result of [Ms A's] death. Obviously life was full of challenges for [Ms A] following [her CVA], however, we do not feel that the care provided during [Ms A's] tenure at Radius St Joans Hospital was less that what would be reasonably expected."

121. In March 2012, the Radius Residential Care Ltd Regional Manager advised HDC that, since the time of Ms A's death, changes have been made to St Joans Hospital, which include the appointment of a new General Manager in early 2011, and the appointment of two Regional Managers assigned to support the Facility Managers.

122. She advised that the Regional Managers perform facility health checks/audits on a regular basis, to ensure that the facility is compliant in all aspects of its operation. The Facility Managers report weekly to their Regional Manager on the outcome of audits, clinical risks that are identified and the actions taken, corrective actions that are being worked on, and all meetings and quality indicators.

123. She stated that other changes made by St Joans Hospital include the following:

- A new wound management plan has been instituted, "to ensure all areas of the wound are covered".
- If a resident loses 3kg, that person is weighed monthly until his/her weight is stable and, if any further loss occurs, the person is referred to a dietitian.
- When a resident is in the terminal stages of his/her care and needs two-hourly turns, a turning chart must be adhered to.
- A DHB clinical nurse specialist is utilised when there are concerning issues regarding resident care.

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RN D

124. RN D said that communication between herself and the RN who was mainly involved in Ms A's care was "very sparse", because the RN tended to report directly to the Facility Manager. RN D stated that she was never directly involved in Ms A's care except for one or two occasions. She said:

> "I was not updated nor was my opinion sort [sic] with regards to any wound unless the EN/RN needed a second opinion. The Doctors rounds were carried out by the RN or EN working in a particular area, therefore the EN was guided by the RN on duty. They would only report to me when concerns occurred. Except for one occasion when the RN requested that I contact the family as [Ms A] was not well."

125. RN D advised that there was inadequate equipment at St Joans Hospital, and that she had requested equipment such as air mattresses and extra low beds, but RN E said that there was no money in the budget for these items. RN D stated:

> "I feel this was a tragic occurrence and my sympathies go out to [Ms A's] family who I never met."

Dr F

126. Dr F advised HDC:

> "[Ms A] was 47. The overall treatment of her pressure sore presented me with a quandary. There were no supporting services prepared to visit and help us with her pressure ulcer care other than the Community Wound Nurse. … Because I felt several of the contributing factors to her lack of wound healing, such as poor nutrition and refusal to allow regular turning, [were] behavioural I referred her back to the Community Neurobehavioural Services (the only psych service prepared to visit her) in the hope that they could help with her lack of motivation to help herself, and in turn her nutrition. They wrote back to me declining to see her.
>
> The only option not explored for [Ms A] was admission to [hospital] for surgical debriding of the ulcer. That was a decision I did not make on [9 Month9], and in hindsight I wish I had done so, but the decision was made thoughtfully and to the best of my ability at the time. For this I extend my heartfelt and sincere apologies to [Mrs B] and her family. Her medical care was my responsibility. I do understand from talking to the nurses and caregivers that [Ms A's] ulceration progressed rapidly over the last few days, but that does not change the fact that the responsibility was ultimately mine."

Responses to provisional opinion

127. Several matters raised in response to my provisional opinion have been incorporated above. The following comments are also noted.

RN C

128. RN C stated:

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> "In hindsight different preventative pressure relief strategies, monitoring and documentation could have been implemented and I take full responsibility for the role I played in [Ms A's] care. With the resources and staff available at St Joans at the time I believe [Ms A] received the best care possible. I am deeply sorry that a sacral pressure area that in my opinion was being well managed during my time at St Joans contributed to [Ms A's] untimely death."

129. RN C provided a written apology for forwarding to Ms A's family, and evidence of the additional training she has undertaken since the events outlined in this report.

RN D

130. RN D stated:

> "I do not dispute any of the information contained within the provisional document. … Unfortunately, I acknowledge that there is not a chance to try and 'get it right' going forward for [Ms A's] family, and this is extremely regrettable. I extend my most sincere apologies to [Ms A's] family and would like to convey my despair in recognising that the final outcomes may have been very different if action around preventative care had been identified and implemented. …
>
> I am actively seeking to further develop my clinical assessment, professional practice and to address any gaps in my current level of nursing knowledge.
>
> As such I have reflected on the facts within the complaint investigation with a commitment to learning from them."

131. RN D provided a written apology for forwarding to Ms A's family, and evidence of the additional knowledge she has gained and training she has undertaken in response to this investigation and the recommendations made in the provisional opinion.

RN E

132. RN E advised that when she became aware of Ms A's pressure sore on 14 Month8 2010, she instructed RN D to contact the wound specialist and dietitian. This was a key step in addressing Ms A's condition, and one that she considers should have been addressed by the Clinical Manager. RN E also pointed out that when she observed Ms A's appearance on the morning of 5 Month9 2010, she addressed this with the nurse in charge and gave instructions. RN E advised that when she found a problem she addressed it, and that it is not her nature to leave matters to resolve themselves.

133. RN E also stated that she responded appropriately to requests for resources to ensure that Ms A had the equipment she required. RN E said that when she commenced her employment at St Joans Hospital in Month3 2010, she arranged for new beds to be purchased, one of which was provided to Ms A (who spent a lot of time in bed). In addition, RN E purchased several pressure relieving devices for "at risk" residents, including a Roho cushion and a Regency chair for Ms A. RN E cannot provide a date for the purchase of this equipment, but pointed out that the earliest record of Ms A's use of the Regency chair is in the Multidisciplinary Review Record form, dated 17 Month6 2010. RN E said that "it is contrary to common sense" that she would have

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prioritised resources for a Regency chair over an air mattress if both were requested. RN E submitted that the notes are consistent with clinicians being content with the progress and treatment of Ms A's pressure sores, and there is no evidence of concern reflecting a request for an air mattress that was refused. RN E's lawyer submitted:

> "While the supply of an air mattress may with hindsight have been clinically justified at some earlier time, it appears from the notes that in light of monitoring and treatment clinical staff were content with [Ms A's] progress, and [RN E] was not aware of any clinical advice or request that an air mattress was required at an earlier time."

134. RN E's lawyer further stated:

> "While finding of [a] breach of the Code on [RN E's] part [is] resisted, [RN E] is sorry for [Ms A's] death. [Ms A's] care presented many challenges, but [RN E] believed she had an experienced team in place to meet those needs. [Dr F] and [RN C] had been at St Joans Hospital since [RN E's] arrival in Month3. [RN E] found [RN C] to be a good communicator and believed she was being properly kept informed of clinical issues at her daily meetings with her. She was not aware [Ms A's] pressure sore was not resolving until 14 [Month8], and as soon as she was aware she called in the specialist nurse from [the] DHB, and did so again on 6 [Month9], all while [Ms A] was under the clinical care of the Clinical Manager and [Dr F]."

Radius Residential Care Ltd (St Joans Hospital)

135. Radius Residential Care Ltd's General Manager Operations, Ms N, responded to the provisional opinion. Ms N stated that Radius has treated this matter seriously and made every effort to prevent a recurrence of anything similar. She acknowledged that the clinical governance and quality structures in place at the time of these events "could have been better", but pointed out that these events occurred three years ago. Ms N stated, "Radius has grown and developed considerably since then" and has developed its systems "across the board over the last [three] years".

136. Ms N noted that Radius has now appointed three Regional Managers and one Operations Manage to oversee and support the Group's Facility Managers and Clinical Managers. A Clinical and Quality Advisor has also been appointed.

137. Ms N referred to the recommendations for improvement from my expert advisor, Mrs Noeline Whitehead, stating that Radius has made the following changes to its service:

- Reporting of pressure injuries: Processes have been tightened so that reporting is now an expected part of dealing with any pressure injury that may occur. Once the incident is analysed, a Corrective Action Plan is developed and interventions put in place and followed through.
- Clinical Governance: A Clinical Governance Framework has been developed for the Radius group which guides and forms the basis of its Quality System. All

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policies and procedures are now evidence based against the most current national and/or international sources. This project is ongoing.

- Management of clinical equipment: The regular audit of all equipment to ensure the equipment is functional at all times, forms part of the Quality System. If the audit falls short then a Corrective Action Plan is developed to attend to the shortfall. An application and approval process has been introduced to ensure that specialist equipment is provided in a timely manner.
- Monitoring of resident fluid intake: Monitoring of fluid intake and hydration of residents has been reviewed and the policies and procedures around this tightened. The appointment of a Clinical Nurse Manager at St Joans Hospital has provided continuity and monitoring of the delivery of care. Regional Managers are monitoring their sites to ensure implementation is appropriate.

138. Ms N outlined the changes that have also been made to ensure that St Joans Hospital's enrolled nurses work within their scope of practice, that differences in the responsibilities of the Facility Manager and Clinical Manager are clearly stated in their job descriptions, and the orientation programme for the Facility and Clinical Managers ensures they are well supported in the first months of employment. Ms N also stated that training and monitoring has been undertaken to ensure effective communication between RNs and the GP. The standards of practice for all health professionals employed by Radius are now monitored as part of the Clinical Governance Framework, to ensure that staff are adequately trained and supported.

Opinion: Introduction

139. As noted by my expert advisor, general practitioner Dr David Maplesden, Ms A was "clearly a complex patient to diagnose and manage", and at times she declined offered positional changes and care provision. I accept that St Joans Hospital staff were faced with some challenges in caring for Ms A. Despite these challenges, Ms A was entitled to have services provided in accordance with her rights under the Code. This included the right to have services provided with reasonable care and skill (Right 4(1)).

140. In 2010, Ms A's condition deteriorated. In Month7 2010 she developed a pressure ulcer that continued to deteriorate, she was tired and frail, she had poor fluid and nutritional intake, and she experienced pain. In my view, aspects of the care and treatment Ms A received — including the response to Ms A's identified risk for pressure ulcers, the management of her pressure ulcers, and the identification of and response to her deteriorating condition in 2010 — were not delivered in accordance with her rights under the Code. For the reasons set out below, I consider that Radius Residential Care Ltd (as the owner/operator of St Joans Hospital) and St Joans Hospital staff, RN C and RN D, breached Ms A's rights under the Code in those areas.

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Opinion: RN C

141. RN C was the Clinical Manager at Radius Residential Care Ltd's St Joans Hospital from Month1 to Month8 2010. As Clinical Manager, RN C had several key responsibilities for Ms A's care, including: ensuring that the standard of care provided to Ms A met the requirements of the Health and Disability Sector Standards; identifying and documenting clinical risk; and identifying clinical quality indicators and reviewing care delivery in relation to quality indicator outcomes. The Health and Disability Sector Standards include the requirement to provide services consistent with a resident's assessed needs,[21] and to ensure that service delivery plans are individualised, updated, describe the required support and interventions required to achieve desired outcomes and demonstrate service integration,[22] and are evaluated in a comprehensive and timely manner.[23]

142. In my view, RN C failed to meet her responsibilities in relation to the care she provided to Ms A. I note that RN C stated that she was not formally orientated to St Joans Hospital, and that she received only minimal support from senior management. Nevertheless, in my view, that does not excuse her failings in this case.

Pressure ulcer prevention — breach

143. In late 2009, Ms A's pressure ulcer risk was assessed using the Waterlow scale assessment tool and found to be 28, which was high. According to St Joans Hospital Pressure Ulcer Guidelines, preventative pressure relieving measures should have been taken in response to that identified risk; however, there is no evidence that such measures were taken at that time.

144. From early 2010, it was RN C's role, as Clinical Manager, to identify and document clinical risk, and to ensure that appropriate action was taken in response to Ms A's identified pressure ulcer risk. RN C did not fulfil her responsibilities to Ms A in that regard.

145. My expert advisor, Mrs Noeline Whitehead, advised me that, by Month2 2010, Ms A was at a very high risk for pressure ulcers. However, there is no evidence that steps were taken to respond to that risk at that time.

146. RN C advised HDC that, in Month4 2010, a number of actions were taken in response to the deterioration in Ms A's condition. In particular, Dr F was contacted regarding Ms A's low mood and reluctance to eat and drink, Ms A was given fluids subcutaneously for 48 hours and provided with Fortisip, Ms A's welfare guardian was contacted, and Dr F referred Ms A to the Neurology and Neurobehavioural clinics at the DHB. RN C also advised that, following discussions with care staff and Ms A, Ms A was moved to a bigger and more suitable room, and a repositioning programme was commenced (including documentation on a turn chart). RN C said that in Month4 or

[21] See: NZS 8134.0:2008 Health and Disability Services (general) Standards 1.8.1, 3.6, and 3.4.2.
[22] See: NZS 8134.0:2008 Health and Disability Services (general) Standard 3.5.2.
[23] See: NZS 8134.0:2008 Health and Disability Services (general) Standard 3.8.

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Month5 2010, a request was made to the Facility Manager to access a suitable alternating air mattress. RN C advised that Ms A was using a Roho cushion at that time, and that staff were advised to continue with regular repositioning and to encourage Ms A to spend time on bed rest in the afternoons. However, the air mattress was not supplied until Month7 2010.

147. HDC has been provided with no evidence of a request for an alternating air mattress in Month4 or Month5 2010. RN E believes RN C is mistaken on this matter and that, when the mattress was requested, it was obtained without delay. In addition, although RN C has said she believes that turn charts were completed, HDC was not provided with turn chart documentation as evidence that such a chart had been implemented.

148. Ms A's Care Plan was updated in Month5 2010, instructing staff to weigh Ms A monthly and record her weight, to encourage her to finish her meals, and to use the Roho cushion when Ms A was in her wheelchair or recliner chair. The updated Care Plan also noted that Ms A's pressure ulcer risk on the Waterlow Scale was 28. Ms A's Care Plan was further updated in Month7 2010 to include the use of an alternating air mattress.

149. Throughout 2010, Ms A's risk of pressure ulcers increased further owing to her poor food and fluid intake and significant weight loss (30kg between Month5 and Month8 2010). A blood test in Month8 2010 identified that Ms A had a protein deficiency, and staff involved in her care reported a general decline in her health and increasing immobility.

150. I am unable to make a finding as to whether RN C requested an alternating air mattress for Ms A in Month4 or Month5 2010. However, in any event, Mrs Whitehead advised me that the pressure ulcer preventative processes for Ms A were inadequate. In particular, suitable pressure relieving surfaces should have been provided from Month2 2010 or earlier, a regimen for changing position should have been included in the Care Plan and updated regularly once Ms A, owing to her declining general health, was unable to turn herself. Mrs Whitehead stated that a detailed record should have been kept of Ms A's position changes; adequate nutrition to ensure adequate protein intake was not maintained; and there was infrequent documentation relating to skin assessments.

151. Mrs Whitehead further advised that pressure relieving surfaces are part of the total programme of prevention and treatment, and need to be properly matched to the needs of the individual and used in accordance with the manufacturer's operating instructions. Mrs Whitehead stated that "without regular weighing staff did not have an accurate weight for Ms A on which to make decisions about the pressure of the air mattress". RN C advised HDC that she checked the positioning of residents daily, including checking the pressure of Ms A's air mattress and Roho cushion. In her response to the provisional opinion, RN C explained that when the scales were out of order in Month6 and Month7, she checked the setting of the mattress by inserting her hand under Ms A's buttocks to gauge the amount of air present in the mattress. There is no evidence of such checks in Ms A's clinical records.

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152. Ms A was at high risk for developing pressure ulcers, and was not eating well. RN C did not respond adequately to that risk. Accordingly, for the reasons set out above, RN C breached Right 4(1) of the Code.

Management of pressure ulcers — breach

153. In Month5 2010, Ms A developed a pressure ulcer that healed; however, a further pressure ulcer developed in Month7 2010. Although a Wound Assessment and Care Plan was developed and maintained for the ulcer in Month5 2010, there is no evidence that such a plan was developed in Month7 2010 when the second pressure ulcer developed, as required by the St Joans Hospital Wound Care Policy. Indeed, the Wound Assessment and Care Plan for that pressure ulcer was not put in place until 14 Month8 2010, after RN C had left St Joans Hospital. RN C advised that a turning regimen for Ms A was implemented; however, no turn charts were provided to HDC.

154. In addition, Ms A did not have a high protein intake, as recommended by evidence-based pressure ulcer guidelines.[24] In my view, RN C should have identified that there was a need for further discussion with the dietitian when the pressure ulcers were first noted, with a view to increasing Ms A's protein intake. There is no evidence that the dietitian was involved in early discussions about pressure ulcer management. Dietitian Ms G was unaware of Ms A's sacral pressure ulcer until she reviewed Ms A on 31 Month8, almost two months after the ulcer was first identified.

155. In my view, the care planning and management of the pressure ulcer that Ms A developed in Month7 2010 was below accepted standards. While RN C relied on the registered nurses to ensure that care plans were implemented, as Clinical Manager it was RN C's responsibility to check that appropriate care plans had been put in place, were adequate, and were being followed. RN C failed to do so, and therefore breached Right 4(1) of the Code.

Hydration — breach

156. Mrs Whitehead advised me that Ms A was generally under-hydrated and, when the decision was made on 8 Month4 2010 to give her subcutaneous fluids, she was probably dehydrated. Following the administration of subcutaneous fluids, staff were instructed to keep a fluid balance chart for Ms A until her condition improved, but it appears that such charts were kept for only a short time in Month4. In addition, there is no evidence that Ms A's poor fluid intake was raised with Dr F. Because RN C had clinical oversight of Ms A, she should have ensured that steps were taken in response to Ms A's poor fluid intake, such as monitoring the fluid balance charts and keeping Dr F updated. By failing to do so, she breached Right 4(1) of the Code.

Monthly weighs — adverse comment

157. Ms A was not eating well, and this should have alerted RN C that Ms A's weight should be carefully monitored. Ms A was not weighed in Month6 and Month7, and this oversight was identified only on 24 Month8 2010, when the visiting Gerontology

[24] Published by the European Pressure Ulcer Advisory Panel (2009). These guidelines are accepted by New Zealand health care practitioners.

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Nurse Specialist reviewed Ms A's wound and found that the pressure relieving alternating air mattress was not correctly adjusted.

158. RN C had a clinical responsibility to ensure that Ms A was weighed monthly. RN C submitted that Ms A was not weighed because the charger for the chair scales was broken, and the ordered replacement had not arrived. RN E stated that it was her responsibility as Facility Manager to ensure that any faulty equipment was fixed and, if there was a missing charger and it was brought to her attention, this was not something to be left unattended. However, RN E said that she was not made aware that the weighing scales were not working for two months.

159. In the circumstances, I am unable to make a factual finding whether the weighing scales were broken and, if they were, whether the matter was brought to RN E's attention. In any event, I note that even if I were to accept RN C's account that the scales were broken, Mrs Whitehead advised that RN C herself had some responsibility to ensure that the necessary equipment was functional. Mrs Whitehead further advised that although RN C's ability to meet the standards and competencies in relation to this matter was affected by systems issues, her peers would regard her failure to ensure that the necessary equipment was functional as a departure from accepted practice. As noted by Mrs Whitehead, "The inability of staff to weigh [Ms A] due to equipment failure contributed to the air mattress being at the incorrect pressure." I accept Mrs Whitehead's advice and recommend that RN C reflect on her contribution to the poor care provided to Ms A.

Documentation — adverse comment

160. Mrs Whitehead advised that there were gaps in the documentation relating to Ms A's deteriorating condition, such as the lack of a detailed turning regimen in the care plans, details of wound assessment and care, and food and fluid intake. Although some of this information was recorded in the progress notes or in the evaluation of the care plan, it was not helpful to have information segmented in different areas of the clinical record, as it would have hindered sharing of the information among Ms A's care team, and thus affected the continuity of the care she received. As the Commissioner has previously noted:

> "Good clinical records are integral to providing care. They demonstrate the reasoning behind the diagnosis, set out the key information upon which decisions about ongoing care are based and can help safeguard practitioners when faced with allegations of inadequate practice. The records are also vital for enabling continuity of care and ensuring other practitioners know what decisions have previously been made and the care that has been provided. Notes need to be comprehensive, accurate, and contemporaneous."[25]

161. I am concerned that the segmentation of the notes documenting Ms A's general condition and her care adversely affected the care that she received from staff at St

[25] Hill, A, "Systems, Patients, and Recurring Themes", *New Zealand Doctor* (9 March 2011). Available at: www.hdc.org.nz.

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Joans Hospital. As Clinical Manager, RN C had a role in ensuring that documentation met accepted standards.[26]

Conclusion

162. As Clinical Manager, RN C was responsible for clinical oversight, and for ensuring that a quality service was provided to the residents at St Joans Hospital, including Ms A. She was also responsible for ensuring that services were provided to Ms A in accordance with the Health and Disability Sector Standards and consistent with her responsibilities as a registered nurse.

163. In my view, RN C did not ensure that a quality service was provided to Ms A, in that RN C failed to: manage Ms A's pressure ulcer risk adequately; ensure appropriate care planning when Ms A developed a pressure ulcer in Month7 2010; and respond to Ms A's poor hydration adequately. In these respects, RN C breached Right 4(1) of the Code.

Opinion: RN D

164. RN D commenced work as Clinical Manager (replacing RN C) at St Joans Hospital in early Month8 2010, approximately four weeks before Ms A was transferred to the public hospital. As Clinical Manager, RN D had several key responsibilities for Ms A's care, including: ensuring that the standard of care provided to Ms A met the requirements of the Health and Disability Sector Standards; identifying and documenting clinical risk; and identifying clinical quality indicators and reviewing care delivery in relation to quality indicator outcomes. The relevant Health and Disability Sector Standards include the requirement to provide services consistent with a resident's assessed needs,[27] and to ensure that service delivery plans are individualised, updated, describe the required support and interventions required to achieve desired outcomes and demonstrate service integration,[28] and are evaluated in a comprehensive and timely manner.[29]

165. In my view, RN D fell short of her responsibilities — including ensuring the monitoring and management of Ms A's food and fluid intake when her condition deteriorated in Month8 2010, and monitoring her vital signs when she was found to have a deteriorating pressure ulcer and elevated temperature in Month9 2010. RN D said that when she started at St Joans Hospital, she was provided with only one day of orientation, and that as a new employee she had to "rely strongly on the competencies

[26] See: Competency 2.3 of the Nursing Council of New Zealand's Competencies for Registered Nurses, which requires that the registered nurse ensures documentation is accurate.
[27] See: NZS 8134.0:2008 Health and Disability Services (general) Standards 1.8.1, 3.6, and 3.4.2.
[28] See: NZS 8134.0:2008 Health and Disability Services (general) Standard 3.5.2.
[29] See: NZS 8134.0:2008 Health and Disability Services (general) Standard 3.8.

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and communication of the RNs". However, in my view, that does not excuse her failings in this case.

Pressure ulcer management — adverse comment

166. On 14 Month8 2010, a Wound Assessment and Care Plan was started for Ms A's pressure ulcer, which described the appearance of Ms A's pressure ulcer, specified the type and frequency of dressings to be applied, and provided for daily review recording. My expert advisor, Mrs Noeline Whitehead, advised me that the Wound Assessment and Care Plan met the guidelines for good wound management and was of an acceptable standard, apart from the detailing of Ms A's turning regimen. A turning regimen should have been included in the care plan and, as Clinical Manager, it was RN D's responsibility to ensure that the care plan was of an adequate standard.

167. I accept Mrs Whitehead's advice that from 14 Month8 2010 the management of Ms A's pressure ulcer was acceptable. In particular, Dr F and the Gerontology Nurse Specialist were appropriately involved in reviewing Ms A and providing advice and input into the management of her pressure ulcer.

168. However, Mrs Whitehead noted that on 2 Month9 2010, Ms A was found to have an elevated temperature and an inflamed pressure ulcer and was started on antibiotics, and therefore in her opinion, on 3 Month9 2010 Ms A's long-term plan should have been reviewed. Mrs Whitehead commented that much of RN D's time in Month8 2010 would have been taken up with orientating herself to St Joans Hospital, and getting to know the residents, and she should have been able to rely on the registered nurses to undertake routine tasks such as reviewing and updating care plans. However, she had responsibility for the clinical oversight of Ms A, whose condition was deteriorating at this time, and RN D should have ensured that such reviews took place.

169. Ms A was using an air mattress. When the Gerontology Nurse Specialist reviewed Ms A on 24 Month8 2010, she noted that the mattress was not being appropriately adjusted to Ms A's weight. Additionally, it was identified at that time that Ms A had not been weighed since Month5 2010. Although the registered nurses at St Joans Hospital should have advised RN D of the extent of Ms A's weight loss, and adjusted the air mattress, RN D had overall clinical responsibility to familiarise herself with the patients under her care and, in Ms A's case, to ensure that the air mattress was set to the correct pressure. Although RN D failed to meet that responsibility in this case, I accept that her omissions are somewhat mitigated by the fact that, as these events occurred within RN D's first weeks at St Joans Hospital, she may not have had a reasonable opportunity to get to know Ms A well enough to identify her weight loss problem.

170. I recommend that RN D reflect on these matters and consider how she can improve her practice in the future.

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Management and monitoring of deteriorating condition — breach

171. On 1 Month9 2010, Ms A's pressure ulcer was noted to be inflamed. Ms A's temperature was elevated at 38.8°C, and this was recorded on a TPR chart, and RN D and Dr F were advised. Dr F visited on 2 Month9, examined Ms A's ulcer and prescribed antibiotics. Ms A's temperature was checked again at 2.50pm on 2 Month9 and again found to be elevated at 38.5°C. This finding was not entered onto the TPR chart, and no instruction was given to increase the monitoring of Ms A's vital signs to four hourly. Ms A was not given her antibiotics until 7am on 3 Month9 2010.

172. Ms A's condition was deteriorating and, as noted by Mrs Whitehead, her wound was obviously presenting as being increasingly infected. However, there is no evidence that Ms A's vital signs were monitored after 3 Month9. Mrs Whitehead advised that once Ms A was noted to have a deteriorating wound and elevated temperature, RN D should have ensured that there was continued monitoring of her vital signs.

173. In Month9 2010, Ms A was under-hydrated and probably dehydrated. RN D was responsible for clinical oversight of Ms A's fluid intake and, although Dr F advised HDC that he knew Ms A was not cooperating with efforts to increase her food and fluid intake, it appears that he was not made aware of Ms A's poor fluid intake. It also appears that Dr F was not advised of the dietitian's concerns about Ms A's ability to swallow, which the dietitian identified when she reviewed Ms A on 28 Month7. Mrs Whitehead advised that monitoring and ensuring that a patient has an adequate fluid intake is expected nursing practice, and she was critical of RN D's failure to ensure that this aspect of Ms A's care was addressed.

174. The wound care records and the progress notes show that Ms A frequently complained of pain. Dr F was advised on 23 Month8 that Ms A was complaining of pain, and he increased her prescribed codeine, but said that he was reluctant to prescribe a stronger analgesic (such as morphine) because of Ms A's poor eating and drinking and compliance with cares. Mrs Whitehead noted that Ms A's prescribed "as required" pain relief was not always given when she reported being in pain (the records show that Ms A sometimes refused offered pain relief), and there is little evidence that the effectiveness of her pain relief was evaluated. RN D, as the Clinical Manager, should have been aware of the need to review the effectiveness of Ms A's analgesia as her condition deteriorated in Month8 and Month9 2010, but there is no record that she did so.

175. In my view, RN D failed to monitor and manage Ms A's deteriorating condition adequately in Month8 and Month9 2010 and, accordingly, breached Right 4(1) of the Code.

Opinion: RN E

176. In Month2 2010, RN E was appointed to the position of Facility Manager at Radius Residential Care Ltd's St Joans Hospital. The Facility Manager is responsible for

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ensuring that standards of clinical practice and service delivery are maintained and the changing needs of residents are met.

177. The Facility Manager is also responsible for managing staff and resources to ensure the delivery of safe and effective quality life and healthcare services to all residents. In addition, the Age Related Residential Care Services Agreement (ARRC) (District Health Boards New Zealand, 2001) provides that the manager's role is to ensure that residents are adequately cared for in respect of their everyday needs, and that services provided to residents are consistent with legislative obligations and the ARRC.

Clinical care — no breach

178. Although I have identified some shortcomings in the clinical care provided to Ms A at St Joans Hospital in 2010, as set out above, in the circumstances of this case, I consider that RN E should have been able to rely on the clinical managers to ensure adequate oversight of the clinical care provided to Ms A. Accordingly, I find that RN E did not breach the Code in respect of the clinical care provided to Ms A in 2010.

Provision of suitable equipment

179. RN C submitted that she requested an alternating air mattress for Ms A in Month4 or Month5 2010, but that the mattress was not provided until Month7 2010. It was RN E's responsibility to ensure that these resources were available to staff caring for Ms A. However, HDC has been provided with no evidence of a request for an alternating air mattress in Month4 or Month5 2010, and RN E believes RN C is mistaken on this matter. RN E submitted that when equipment was requested from her, including the mattress, it was obtained without delay, and that there is no evidence of concern in the clinical records reflecting a request for an air mattress that was refused.

180. I accept RN E's submission that she purchased several pressure relieving devices that were provided to Ms A, including a new bed, a Roho cushion, and a Regency chair. In the circumstances, I am unable to make a finding as to whether or not RN C requested an alternating air mattress for Ms A in Month4 or Month5 2010 and/or whether or not there was any delay in that request being actioned.

181. RN C also advised HDC that staff were unable to weigh Ms A in Month6 and Month7 2010 because the charger for the chair scales had broken. In response to the provisional opinion, RN E accepted that, as the Facility Manager, it was her responsibility to ensure that faulty or broken equipment was repaired, once it was brought to her attention, and that if there was a missing charger, this was not something to be left unattended. However, RN E stated that she was not aware that the scales could not be used for two months, or that a replacement charger had not been supplied. In the circumstances, I am unable to make a factual finding as to whether or not the weighing scales were broken and, if they were, whether or not the matter was brought to RN E's attention.

Antibiotic administration — no breach

182. Dr F prescribed antibiotics for Ms A on 2 Month9 2010. Ms A did not receive the first dose of the antibiotic until 7am the following day. It is unclear why there was a delay

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in the antibiotics being provided; however, the more than 12-hour delay in administering the antibiotic was clearly inadequate. In my view, it was RN E's responsibility as Facility Manager to ensure that there was a system in place at St Joans Hospital for the prompt commencement of antibiotics once prescribed.

183. In response to the provisional opinion and Mrs Whitehead's concern that there was no effective system for the prompt commencement of antibiotics, RN E stated that St Joans Hospital had a medication policy that addressed the timely administration of medications. The system required the duty RN to fax a new prescription to the supplying pharmacy, and for the medication to be delivered promptly. RN E noted that Dr F prescribed the antibiotic for Ms A to be given at 7am, 3pm and 8pm. As Ms A was given the antibiotic at 7am on 3 Month9, the medication must have been delivered the previous evening. RN E stated that the facts show that there was a system in place, but the delay in administering the antibiotic in the evening of 2 Month9 likely occurred because of an oversight by a registered nurse. I accept RN E's submission and, although I consider that the delay was clearly inadequate, I find that RN E did not breach the Code in this respect.

Wound management — no breach

184. The wound products for Ms A's sacral pressure wound, recommended by RN M on 9 Month9 2010, were not provided. As noted by Mrs Whitehead, it was RN E's responsibility to ensure that the wound products recommended by the wound specialist on 9 Month9 2010 were provided promptly.

185. In response to the provisional opinion, RN E stated that she recorded in the progress notes on 10 Month9 2010 that the new dressing products RN M recommended had been ordered. RN E stated that the Intrasite Comfortable, a specialised product, was not stocked by their usual wound product supplier, hence her note that the dressing would "hopefully" be available on Monday. She instructed the duty registered nurse to ask RN M to recommend an alternative dressing until the Intrasite Comfortable could be obtained. In these circumstances, I find that RN E did not breach the Code in this respect. I also note RN E's submission that when she became aware of Ms A's pressure sore on 14 Month8 2010, she instructed RN D to contact the wound specialist and dietitian. This was a key step in addressing Ms A's condition.

Summary

186. It was RN E's responsibility to manage staff and resources to ensure the delivery of safe and effective quality life and healthcare services to all residents. Although I accept that there were shortfalls in the clinical care provided to Ms A at St Joans Hospital in 2010, as outlined above, in the circumstances I find that RN E did not breach the Code in respect of the clinical care provided to Ms A, including the delay in administering antibiotics to Ms A in Month9 2010, follow-up of the recommended wound care products, provision of an air alternating mattress, and the delay in repairing the scales.

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Opinion: Radius Residential Care Ltd (trading as Radius St Joans Hospital)

187. As identified above, St Joans Hospital staff (RN C and RN D) did not provide services to Ms A with reasonable care and skill, or in accordance with professional standards. The care provided to Ms A fell below expected standards in the following areas: pressure ulcer prevention; pressure ulcer management; the monitoring of, and response to, Ms A's deteriorating condition; and the adequacy of the documentation of Ms A's care and treatment at St Joans Hospital.

188. I have carefully considered the extent to which the deficiencies in Ms A's care occurred as a result of individual staff action or inaction, as opposed to systems and organisational issues. Radius Residential Care Ltd (Radius), as the owner and operator of St Joans Hospital, had the overall responsibility to ensure that Ms A received care that complied with the Code. In order to do so, Radius needed to provide its employees with adequate policies and procedures to guide their actions and ensure they received adequate training. In addition, Radius needed to monitor staff compliance with the policies and procedures.

189. Radius also has responsibilities under the Age Related Residential Care Services Agreement (ARRC) (District Health Boards New Zealand, 2001). Those responsibilities include: ongoing review and evaluation when there is a significant change in the resident's clinical condition;[30] that all residents have a care plan that staff follow;[31] supplying dressings and supplies used in treatment;[32] and providing equipment for personal care or the general mobility needs of residents who require them, including pressure relief (including mattress, heel protectors and seat cushions), and sufficient clinical equipment, including weighing scales.[33]

190. In my view, Radius is responsible for a number of the inadequacies in the care provided to Ms A at St Joans Hospital, including staff orientation and performance monitoring, and ensuring appropriate equipment was available. Radius was also responsible for ensuring that there was adequate staffing at St Joans Hospital, and adequate documentation of care.

Care provided in 2010 — breach, vicarious liability

191. While I have identified my concerns about the actions of RN C and RN D, Radius also had a responsibility to operate St Joans Hospital in a manner that provided Ms A with services of an appropriate standard. That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It also includes responsibility for the actions of its staff. Radius's responsibility for

[30] See: D16.3 and D16.4 of the ARRC.
[31] See: D16.3 of the ARRC.
[32] See: D18.3 of the ARRC.
[33] See: D15.3 of the ARRC.

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the actions of its staff is set out in section 72 of the Health and Disability Commissioner Act 1994, which provides that an employer is liable for the acts or omissions of an employee unless the employer can show that it took such steps as were reasonably practicable to prevent the employee from breaching the Code.

192. As noted above, the care Ms A received at St Joans Hospital in 2010 fell below expected standards in several respects, including staff response to Ms A's risk of pressure ulcer development, the management of the pressure ulcer she developed in Month7 2010, and the management of her deteriorating condition in 2010. Radius provided St Joans Hospital staff with policies relating to pressure ulcer prevention and management, wound care, and pain management. The pressure ulcer guidelines set out the risk factors, and assessment and management of risk, and also describe the stages of development of a pressure ulcer and refer staff to associated policies such as care planning, treatment, and evaluation of ulcers. However, those policies were not always followed.

193. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and assist staff to do what is required of them,[34] and, without staff compliance, policies become meaningless.[35]

194. Radius had a responsibility to ensure that staff complied with policies and provided services with reasonable care and skill, and it failed to do so in this case. Accordingly, Radius is vicariously liable for the failures by its staff, and breached Right 4(1) of the Code.

Orientation and performance monitoring — breach

195. RN C and RN D both reported that they received little to no support or orientation when they commenced their role as Clinical Manager at St Joans Hospital.

196. When RN C commenced as Clinical Manager in Month1 2010, the Facility Manager at that time was on sick leave, and so RN C was expected to cover the Facility Manager role at the same time as orienting to the Clinical Manager role. In my view, it was inappropriate for Radius to expect a newly appointed Clinical Manager to orient to her new role while at the same time acting as Facility Manager. By doing so, Radius compromised the quality of care of St Joans Hospital residents. Radius should have made other arrangements for cover for the Facility Manager role, and should have ensured that RN C was adequately supported and oriented to her role as Clinical Manager.

197. RN D also reported that she had one day of orientation when she started at St Joans Hospital. This was clearly insufficient.

[34] Opinion 07HDC16959 (20 May 2008) and Opinion 10HDC00308 (29 June 2012).
[35] Opinion 09HDC01974 (21 June 2012).

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198. My expert advisor, Mrs Noeline Whitehead, noted that the Radius orientation checklist for registered and enrolled nurses does not specifically cover some aspects of nursing practice, such as comprehensive assessment, direction, and delegation. There is also no information about the expected responsibilities of visiting health professionals. Mrs Whitehead stated that the level of orientation that could have been reasonably expected by new senior nurses was not provided.

199. Mrs Whitehead commented that although registered nurses provided oversight of patient care and contributed to Ms A's care management, it appears that an enrolled nurse was responsible for Ms A's care on some days. Mrs Whitehead stated that Ms A was a complex patient, and there should have been performance review systems in place to ensure that enrolled nurses were working within their scope of practice, and that they were effectively directed by a registered nurse.

200. In my view, Radius had a responsibility to ensure that staff were adequately oriented to, and supported in, their roles at St Joans Hospital. Radius failed to fulfil that responsibility and breached Right 4(1) of the Code.

Equipment — adverse comment

201. The ARRC provides that Radius must provide the necessary equipment for personal care or the general mobility needs of residents, which includes pressure relief equipment and scales.

202. RN C submitted that she requested an alternating air mattress for Ms A in Month4 or Month5 2010, but that the mattress was not provided until Month7 2010. It was RN E's responsibility to ensure that these resources were available to staff caring for Ms A. However, HDC has been provided with no evidence of a request for an alternating air mattress in Month4 or Month5 2010, and RN E believes RN C is mistaken on this matter. RN E submitted that when equipment was requested from her, including the mattress, it was obtained without delay, and that there is no evidence of concern in the clinical records reflecting a request for an air mattress that was refused.

203. As noted above, I accept RN E's submission that she purchased several pressure relieving devices that were provided to Ms A, including a new bed, a Roho cushion, and a Regency chair. In the circumstances, I am unable to make a finding as to whether or not RN C requested an alternating air mattress for Ms A in Month4 or Month5 2010 and/or whether or not there was any delay in that request being actioned by Radius. However, as noted by Mrs Whitehead, pressure relieving surfaces are part of the total programme of prevention and treatment, and should have been made available to Ms A in Month2 2010, if not earlier.

204. RN C also advised HDC that staff were unable to weigh Ms A in Month6 and Month7 2010 because the charger for the chair scales had broken. In response to the provisional opinion, RN E stated that she was not aware that the scales were broken for two months, or that a replacement charger had not been supplied. In the circumstances, I am unable to make a factual finding whether or not the weighing scales were broken and, if they were, whether or not Radius was on notice of the

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faulty equipment. Accordingly, I find that Radius did not breach the Code in that respect.

Staffing — adverse comment

205. Ms A's day-to-day clinical care was undertaken by nursing staff, which included both registered and enrolled nurses. Enrolled nurses are required to practise under the direction and delegation of a registered nurse.

206. The records indicate that, on some days, an enrolled nurse was responsible for Ms A's care. Mrs Whitehead advised:

> "In my opinion, [Ms A] was a complex patient and her weight loss indicated that she might not [be] [clinically] stable at times. I question whether an enrolled nurse should have been managing her care. I note that [registered nurses] provided oversight and [registered nurses] contributed to her care management."

207. I accept Mrs Whitehead's comments and encourage Radius to ensure that the enrolled nurses at St Joans Hospital are always practising under the direction and delegation of a registered nurse, and that care is taken before assigning an enrolled nurse responsibility for patients with complex needs on any given day.

Documentation — adverse comment

208. Mrs Whitehead advised that there were gaps in the documentation relating to Ms A's deteriorating condition, such as no detailed turning regimen in the care plans, incomplete details of wound assessment and care, and incomplete details of food and fluid intake. While some of this information was recorded in the progress notes or in the evaluation of the care plan, it was not helpful to have information segmented in different areas of the clinical record, as this would have hindered sharing of the information among Ms A's care team, and thus would have affected the continuity of the care she received. In addition, there was a lack of completed incident forms in relation to Ms A's ulcers.

209. The importance of good documentation cannot be overstated. As the Commissioner has previously noted:

> "Good clinical records are integral to providing care. They demonstrate the reasoning behind the diagnosis, set out the key information upon which decisions about ongoing care are based and can help safeguard practitioners when faced with allegations of inadequate practice. The records are also vital for enabling continuity of care and ensuring other practitioners know what decisions have previously been made and the care that has been provided. Notes need to be comprehensive, accurate, and contemporaneous."[36]

[36] Hill, A, "Systems, Patients, and Recurring Themes", *New Zealand Doctor* (9 March 2011). Available at: www.hdc.org.nz.

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210. I am concerned that the segmentation of the notes documenting Ms A's general condition and her care adversely affected the care that she received from staff at St Joans Hospital. Radius's documentation was suboptimal, and Radius should reflect on this to improve its future practice.

Conclusion

211. As the owner/operator of St Joans Hospital, Radius has ultimate responsibility for ensuring that its residents receive appropriate, timely, and safe care. Senior staff stated that the clinical governance and quality structures at St Joans did not provide adequate support to ensure that they were able to fulfil their responsibilities. This appears to be supported by the 100% senior staff turnover in less than a year. In my view, Radius is vicariously liable for the breaches of the Code by RN C and RN D. In addition, in my view, Radius failed in its responsibility to Ms A because it did not ensure that staff were adequately oriented and supported. Accordingly, Radius breached Right 4(1) of the Code.

Opinion: Dr F

212. Dr F took over the care of Ms A in late 2009, as part of his duties as medical officer at St Joans Hospital. Dr F first saw Ms A's sacral pressure ulcer on 16 Month8 2010, and he rechecked it on 26 Month8, 2 Month9 and 9 Month9 2010. On 2 Month9, Dr F prescribed antibiotics.

213. HDC's clinical advisor, general practitioner Dr David Maplesden, was asked to review the care that Dr F provided to Ms A, in light of Mrs Whitehead's comments about Dr F's management of Ms A's medication and deteriorating health. In Dr Maplesden's opinion, Dr F's consultations with Ms A "were frequent and were generally followed up with appropriate investigations and treatment". Dr Maplesden advised that Dr F's role in pressure ulcer management was "to review the pressure ulcer at a frequency he felt was appropriate based on his impression of the status of the ulcer and on feedback from nursing staff as to its progress". Dr Maplesden further advised, "Had there been evidence of infection, antibiotics preceded by swabbing the wound would be indicated". Dr Maplesden noted that when it was identified on 2 Month9 2010 that the wound was infected, Dr F prescribed antibiotics and took a swab of the wound, which was appropriate.

214. Dr Maplesden advised that it is difficult to comment on whether surgical debridement of the pressure ulcer was warranted earlier. He noted that it "perhaps should have been considered when there was no progress being made on 9 Month9 2010 in spite of antibiotic treatment, although this would depend to some extent on the nature and depth of the ulcer". Dr Maplesden noted that Dr F last reviewed Ms A's ulcer on 9 Month9 2010, and advised, "The fact that the ulcer had involved subcutaneous tissues and muscle by 12 [Month9] 2010 indicates management was sub-optimal and [Dr F] must take some responsibility for this."

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215. Dr Maplesden was also "mildly critical" of Dr F's failure to actively review Ms A's blood pressure medication, or direct more intensive monitoring of her blood pressure "in light of her hypotensive episodes and general unwellness from 25 [Month8] 2010". Dr Maplesden stated that assessment of blood pressure should have been part of Dr F's overall assessment of an unwell patient on 2 and 9 Month9 2010. Dr Maplesden also stated that ongoing regular monitoring of Ms A's vital signs was indicated in Month9 2010. Overall, Dr Maplesden stated:

> "There were some deficiencies in the care offered by [Dr F] to [Ms A]. … I feel these were, under the circumstances, generally of a mild nature."

216. Dr F acknowledged that the responsibility for the management of Ms A's care was "ultimately" his, and he regrets not making the decision on 9 Month9 2010 to arrange for Ms A to be admitted to the public hospital for treatment and ongoing management of her pressure ulcer. He said:

> "For this I extend my heartfelt and sincere apologies to [Mrs B] and her family. Her medical care was my responsibility."

217. I agree with Dr Maplesden's view that there were aspects of the service Dr F provided to Ms A that could have been better managed. I note that Dr F has acknowledged his omissions of care and states that he has seriously reflected on these matters and has learnt from them.

Recommendations

218. In my provisional opinion, I made the following recommendations in relation to RN D, RN C, and Radius Residential Care Ltd (St Joans Hospital):

1. RN D:
   - To provide a written apology to Ms A's family.
   - To review her practice in relation to care planning, monitoring and supervision of staff in light of this report.
2. RN C:
   - To provide a written apology to Ms A's family.
   - To review her practice in relation to risk assessment, care planning, monitoring, documentation and staff supervision, in light of this report.
3. Radius Residential Care Ltd (St Joans Hospital):
   - To provide a written apology to Ms A's family.

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- To review the issues identified by Mrs Whitehead as "Recommendations for improvement".
- To review staff orientation, performance management and training in relation to the assessment and monitoring of clients.

219. In response to my provisional opinion, RN D provided a written apology to Ms A's family, and provided evidence that she has reviewed her practice in relation to care planning, monitoring, and supervision of staff.

220. In response to my provisional opinion, RN C provided a written apology to Ms A's family, and has provided evidence of recent training in nutrition and hydration, skin management and wound care, and documentation.

221. In response to my provisional opinion, Radius Residential Care Ltd (St Joans Hospital) advised that:

- it has reviewed the issues identified by Mrs Whitehead as "Recommendations for improvement", and implemented a number of changes (see paragraph 137); and
- it has reviewed staff orientation, performance, and training in the assessment and monitoring of clients.

222. As per my provisional recommendation 3, I recommend that Radius Residential Care Ltd (St Joans Hospital) provide a written apology to Ms A's family for its breach of the Code. The apology is to be forwarded to HDC by **9 December 2013** for sending to Ms A's family.

Follow-up actions

223.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Radius Residential Care Ltd (St Joans Hospital), will be sent to the District Health Board, the Ministry of Health, and the New Zealand Aged Care Association.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Radius Residential Care Ltd (St Joans Hospital), will be sent to the Nursing Council of New Zealand, and it will be advised of RN C, RN E and RN D's names.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Radius Residential Care Ltd (St Joans Hospital) will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Expert nursing advice

Expert advice was obtained from an independent nurse, Mrs Noeline Whitehead, who has experience in aged care. The background, summary of advice requested, summary of information provided, and summary of facts have been removed for brevity. Mrs Whitehead's advice is as follows:

"*Pressure ulcer development and management*
The development and progress of pressure ulcers is summarised in Table 1. [Ms A] was very high risk for pressure ulcers in [early] 2010. The risk of developing a pressure ulcer was further increased by:

- Significant weight loss due to declining appetite, nausea and vomiting
- Nutritional factors (nausea, poor food intake, weight loss and anaemia)
- Under-hydration
- Use of restraints
- Declining general health
- [Ms A's] right to refuse care
- Her increasing immobility.

There was a small broken area of skin reported as early as [Month5] 2010. There was no documentation of the size of the pressure ulcer. These broken areas were reported to heal and then to break down again. A pressure ulcer was noted in the progress notes on 2 [Month7] 2010 and the progress continued to be reported. The assessment and care plan for this pressure ulcer commenced on 14 [Month8] 2010, completed consistently from this point on with the last entry on 11 [Month9] 2010. On 14 [Month8] 2010, the pressure ulcer was described as stage two. However, it appeared to be partial thickness as it was 2cm deep and 2.5cm wide, so was more likely to be a stage three ulcer. There is clear evidence that the wound was not healing and in fact was deteriorating rapidly from a grade 3 to a grade 4 ulcer. RNs/EN reported increasing size, necrosis, odour, inflammation, and pain related to the pressure ulcer.

The facility manager sought expert advice from the GCNS [Gerontology Clinical Nurse Specialist] and GP. The GP was consulted regularly regarding the pressure ulcer from 14 [Month8] 2010 onwards. I note that there is a difference in the state of the pressure ulcer recorded by the RNs on the wound care record and the description recorded by the GP. The RNs were of the opinion that the wound was more infected that the GP did. He noted there was localised inflammation. The GP prescribed antibiotic therapy (Flucloxacillin) on 2 [Month9] 2010. The wound swab confirmed that the bacteria in the wound were sensitive to this. I note that the pressure ulcer had deteriorated by 8 [Month9] 2010; it had increased in size, was more necrotic/very inflamed, tender, with high exudate, and high odour. The RNs reported that it 'was infected'. The GP last inspected the pressure ulcer on 9 [Month9] 2010, noting 'not healing, no infection, and MSU negative'. The GP referred [Ms A] to the Community Neurobehavioral Service for assessment.

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Table 1: Summary of pressure ulcer development

Date	Description	Resolved
7 [Month5] 2010	Broken area right buttock.	19 [Month5] 2010
3 [Month6] 2010	Dressing to sacrum.	18 [Month6] 2010
19 [Month6] 2010	Groin excoriated.	
28 [Month6] 2010	Seen by GP — prescribed treatment for groin.	
30 [Month6] 2010	Groin excoriated with broken areas.	
2 [Month7] 2010	Broken area on the coccyx.	
7 [Month7] 2010 10 [Month7] 2010	Area was healing.	
14 [Month7] 2010	Broken area present.	
1 [Month8] 2010	Sacral pressure area.	
4 [Month8] 2010	Sacral pressure area.	

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8 [Month8] 2010		
11 [Month8] 2010	Sacral pressure area.	
13 [Month8] 2010	[Ms A] complained of a sore sacrum.	Staff reported no broken area was observed (entry not signed).
14 [Month8] 2010	Wound care assessment and treatment recorded commenced.	
16 [Month8] 2010	Pressure ulcer bigger and deeper. GP reviewed the wound stated it was not infected. Staff also recorded on 17 [Month8] 2010 that the wound did not appear infected.	
24 [Month8] 2010	Wound reviewed by GCNS.	
25 [Month8] 2010	Staff reported that [Ms A] was sweaty and blood pressure was 92/42. Wound was reported sloughy for the first time. Reported to the Clinical Manager.	
27 [Month8] 2010	Wound care record recorded a change in the wound in that the wound was now infected, with heavy exudate, moderate odour, and had deteriorated.	
28 [Month8] 2010	[Ms A] was reported to be very sweaty with a low blood pressure, 92/43, pulse 68 and that [Ms A] was slow to respond. Staff reported that this was because of a heavy blanket. Her temperature and oxygen saturation were not reported on.	Later in the day, her temperature was reported to be 36.1^{o} C.
29 [Month8] 2010	Pressure ulcer slightly inflamed in progress notes. On the wound care plan the wound was recorded as slightly inflamed, granulating with moderate exudate and odour.	

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30 [Month8] 2010	Pressure ulcer not improving.	
31 [Month8] 2010	Reviewed by dietician and nutrition plan updated to include a supplement.	
1 [Month9] 2010	Staff state the wound infected and refer to GP.	Temperature 38.8
2 [Month9] 2010	Seen by GP — he stated the wound was only slightly infected and commenced antibiotics and ordered a wound swab.	Temperature 38.5 on 3 [Month9] 2010.
5 [Month9] 2010	Wound necrotic.	
6 [Month9] 2010	Facility manager reviewed the wound.	
7 [Month9] 2010	Referral to the gerontology clinical nurse specialist.	
9 [Month9] 2010	Wound deteriorating fast. Facial expressions of pain but refused pain relief. The CNS and the GP inspected the pressure ulcer.	
10 [Month9] 2010 to discharge	[Ms A] was sleepy, fatigued, did not recognise the staff and only drinking Fortisip.	
12 [Month9] 2010	[Ms A] had a very elevated temperature, low blood pressure and reduced level of consciousness.	Temperature 40.8 Blood pressure 90/60

On 25 [Month2] 2010, staff recorded a very high Waterlow pressure risk score of 28. The care plan was re-written on 20 [Month5] 2010 and included a requirement for daily assessment of the skin, and moisturisers. It stated that [Ms A] was able to turn herself.

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On 8 [Month7] 2010, staff updated the plan to include an air mattress. On 14 [Month8] 2010, staff again updated the care plan to include a Roho cushion and the need for the air mattress to be set to body weight. A short-term care plan dated 3 [Month9] 2010, addressed the inflammation of the pressure cavity on the sacrum. The progress notes recorded that staff explained this care plan to [Ms A] and her mother. Staff recorded progress on the wound assessment/care plans from 14 [Month8] 2010 until discharge.

I note that the Roho cushion was not on the chair on 2 [Month7] 2010. The physiotherapist reported that the cover had gone to the wash on 30 [Month6] 2010. The Roho cushion cover was located on 2 [Month8] 2010. The physiotherapist noted the pressure ulcer in progress notes, repositioned [Ms A] on a Roho cushion, and ordered her to be turned every two hours. The use of the Roho cushion was confirmed on 02 [Month8] 2010 — it appears that it may not have been used since the 30 [Month6] 2010.[37]

An air mattress was in place on 18 [Month7] 2010. RN C stated, 'one was not available prior to this'. The physiotherapy aide and RN C carried out the daily checking of the air mattress. [Ms A] had not been weighed since 2 [Month5] 2010. Therefore, ensuring that the air mattress was set at the correct pressure was based on a weight that was likely to have been inaccurate. At the end of [Month8] 2010, the GCNS reported that the air mattress pressure was not consistent with the pressure required for [Ms A's] actual weight. This increased the risk of the pressure ulcer deteriorating.

Pain management

It is clear from the progress notes, pain charts kept from 25 [Month8] 2010 to 11 [Month9] 2010, and the wound care plan that [Ms A] suffered pain regularly. The medication records indicate that pain relief (paracetamol and codeine) was given p.r.n. until 1 [Month8] 2010 when the GP changed codeine to twice a day. Paracetamol was continued p.r.n. averaging no more than two doses a day. The evidence suggests that [Ms A] was still in pain. The GP stated in his letter that he was reluctant to prescribe morphine.

Nutrition, weight loss, and hydration

[Ms A] had been on a strict weight loss diet for morbid obesity with positive results. In a letter dated 19 [Month1] 2010, the dietician stated that [Ms A's] goal weight was 120kgs. [Ms A] reached this weight in 2009. I have been unable to establish whether a new goal was set or whether it was considered that [Ms A] had reached an acceptable weight. [Ms A] had a 29 percent weight loss in the six months [leading] to [Month8]. A 21 percent decrease in weight occurred between

[37] See paragraphs 62 and 76. The Incident Report completed on 2 [Month7] 2010 refers to the cushion being reapplied that day. Following receipt of Mrs Whitehead's advice, further information was obtained from RN C. It appears the Roho cushion was unavailable for use between 30 Month6 and 2 Month7 2010, rather than throughout Month7.

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[Month5] and [Month8] 2010. The dietician ordered a diet with no restrictions on 31 [Month8] 2010 and charted Fortisip.

Table 2: [Ms A] weights were recorded as:

Month	**Kgs**		**Month**	**Kgs**
[Early] 2009	128.5		[Month4] 2010	Not weighed unwell
[Mid] 2009	111		[Month5] 2010	95
[Late] 2009	100		[Month6] 2010	No entry
[Month1] 2010	101.6		[Month7] 2010	No entry
[Month2] 2010	105.7		[Month8] 2010	75.1
[Month3] 2010	98			

The dietician's notes dated 5 [Month5] 2010 instructed that [Ms A] should be weighed monthly, that the Fortisip was to be stopped and the low fat diet was to continue with choices to be offered if [Ms A] refused to eat her diet. These instructions were entered in the care plan on 20 [Month5] 2010. [RN C] states that the dietician requested a referral to a speech language therapist as [Ms A] was having difficulty swallowing and that the GP was asked to make this referral. On 13 [Month5] 2010, there is an entry in the progress notes suggesting a referral be made to a speech language therapist (I cannot identify the designation of this person). [RN C], in her response, states that in '[Month7] 2010 staff were unable to weigh [Ms A] as the charger for the chair scales was broken and a replacement one had not arrived'. She also states '[Ms A] would refuse to be weighed'.

On 28 [Month7] 2010, the dietician noted that [Ms A] appeared as though she had lost weight and requested monthly weights. The dietician did not check that this occurred until her next visit at the end of [Month8]. The dietician also noted that [Ms A's] swallowing ability continued to deteriorate and suggested that a speech language referral may be required. On 23 [Month8] 2010, the staff reported in the progress notes that [Ms A's] weight was unstable, there was a large loss, the wheelchair needed adjusting, and that [Ms A] needed to be seen by the doctor.

On 31 [Month8] 2010, the dietician reviewed [Ms A] stating that she had lost 20kg since [Month5] and revised the dietary plan to include Fortisip, discontinued the low fat diet and recommended that blood tests should be undertaken for haemoglobin and serum protein. Results of these tests, dated 10 [Month9] 2010, indicate that [Ms A] had a low haemoglobin and serum protein both reflective of her poor food intake.

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[Ms A] was treated with subcutaneous fluids for the period 9 [Month5] 2010 and 11 [Month5] 2010. There was an instruction to continue the fluid balance charts until [Ms A's] intake improved. [Ms A's] fluid intake did not appear to improve. No fluid balance charts have been provided from this time until the food records kept in [Month9] 2010. The food charts indicate that [Ms A's] intake was less than 1000mls a day. [Ms A] was likely to have been under-hydrated/dehydrated during this time.

Obtaining and sending specimens to the Laboratory
There is evidence in the progress notes and the laboratory reports that specimens ordered by the GP were collected. There is evidence that for urine samples, there were delays related to [Ms A's] incontinence. There was one occurrence in [Month5] 2010 where an MSU [was] requested and in [Month7] 2010 where there was a considerable delay from the time of the recording of the request for a urine specimen by the GP to confirmation that it was received by the laboratory. There was also a delay in the laboratory staff collecting a repeat set of faecal specimens. Staff reported difficulty in obtaining these specimens.

Monitoring health status
Nurses reported that [Ms A's] wound looked inflamed and had a strong odour. On 1 [Month9] 2010 [Ms A] was reported (only on the vital signs reporting sheet) to have an elevated temperature (38.8^{o}C). I have been unable to establish if the GP was advised. The GP did see [Ms A] on 2 [Month9] 2010 regarding her infected wound and prescribed antibiotics. The first dose was not signed for until 0700 hours on 3 [Month9] 2010. On 3 [Month9] 2010, staff recorded in the progress notes that [Ms A] had a temperature of 38.5^{o}C. [Ms A's] mother was notified. By that afternoon, [Ms A's] temperature was normal (36.6^{o}C). [Ms A's] temperature was recorded as normal again on 4 [Month9] 2010. There is no evidence that there was monitoring of vital signs past this date even though [Ms A's] wound was obviously deteriorating and presenting as being increasingly infected and her general condition was deteriorating.

General care
There is consistent reporting of the provision of basic hygiene and when [Ms A] refused care it was recorded in the progress notes. There were instructions to reposition her two hourly and some reporting that this was completed in the progress notes. While [Ms A] may have resisted being repositioned this is not clearly stated in the progress notes. [Ms A] appeared to be spending most of her time in bed. There is an entry that the facility manager was not happy with [Ms A's] care on a particular day and there is evidence that this was addressed.

I note that [Ms A] was prescribed 25 different medications. A number of these medications have side effects that could have accounted for [Ms A's] nausea, vomiting, and poor appetite. I have not been provided with evidence that medications were reviewed three monthly by the GP. Blood levels for Epilim and Dilantin were completed.

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Documentation
In the main, the level of documentation is adequate. It provides a picture of [Ms A's] care needs, the care provided, and her progress. There is good evidence of communication with [Ms A's] mother and the welfare guardian on the communication sheets, in the progress notes and in the care review reports. There is lack of documentation regarding fluid intake between [Month5] and [Month9] and the lack of a wound assessment and care plan for the pressure ulcer between 2 [Month7] 2010 and 13 [Month8] 2010. There is a lack of a detailed turning regime for [Ms A] once she could no longer turn herself.

Section Five

Findings
[Ms A's] age and borderline personality [disorder] increased the challenge for care staff in the provision of care. [Ms A] was non-compliant with positional changes and care processes at times. [Ms A's] general condition was declining over a number of months as indicated by the dietician's reports, nursing and GP progress notes. These notes reflect the development of a pressure ulcer that continued to deteriorate, a pattern of increasing tiredness and frailty, poor fluid intake, ongoing lack of appetite, nausea, and vomiting. In addition, [Ms A] appeared to suffer some level of confusion in [Month9]. [Ms A] suffered a low haemoglobin raised ferritin and serum albumin just prior to and on admission to [the public] Hospital.

Pressure ulcer prevention
In my opinion, the preventative strategies such as those recommended in evidence-based pressure ulcer guidelines such as those published by the European Pressure Ulcer Advisory Panel (2009) as set out on section D1 were not effectively implemented as follows:

1. Suitable pressure-reducing surfaces (such as the air mattress and Roho cushion) were required from [Month2] 2010 or even earlier.
2. A regime for changing position should have been included in the care plan and updated regularly once [Ms A] was unable to turn herself.
3. A detailed record should have been kept of [Ms A's] position changes. There were numerous entries in the progress notes that [Ms A's] position was to be changed two hourly. There was no indication as to how it was decided that this regime was suitable for [Ms A].
4. The care plan required daily skin assessments and the outcome documented. There was infrequent documentation of these skin assessments. This may have been because only exceptions to [Ms A's] normal skin condition were being reported, but this is not clear.
5. Adequate nutrition to ensure adequate protein intake was not maintained.

In summary, the pressure ulcer preventive processes were inadequate in respect of the use of pressure-reducing surfaces, adequate nutrition, and a detailed turning regime, especially in view of the general decline in [Ms A's] health and weight loss of a level that was cause for concern.

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Pressure ulcer management
In my opinion, the wound care provided from 14 [Month8] 2010 to 9 [Month9] 2010 met the guidelines for good wound management as set out in section D2 as follows:

1. Wound care recommendations included cleansing the pressure ulcer and surrounding skin each time the dressing was changed. The wound was cleaned by irrigation in the latter stages that was appropriate. Wound care products that were used were designed to clean the ulcer and promote moist wound healing.
2. The RNs/EN sought timely advice of GP.
3. The senior RNs sought expert advice from the GCNS. The RNs implemented the expert advice following the first assessment. However, the recommendations of the CNS made on 9 [Month9] 2010 were not implemented, as the products required were not available and had to be ordered in.

In my opinion, once the wound became necrotic with heavy exudate and odour and the presence of infection as it was when reviewed by the GP on 9 [Month9] 2010, further specialist advice should have been sought. The wound management may have been inadequate prior to 14 [Month8] 2010. The lack of evidence may indicate failure to adequately assess, report, and implement plan of care when the pressure ulcer was in its early stages in my opinion contributed to the deterioration of the pressure ulcer.

Air Mattress and Roho cushion
The recommendation is to provide support surfaces that are properly matched to the individual's need for pressure redistribution, shear reduction, and microclimate control. Support surfaces alone neither prevent nor heal pressure ulcers. They are part of a total programme of prevention and treatment. The air mattress and Roho cushion are considered appropriate pressure reducing surfaces for residents that are high risk for developing pressure ulcers (European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel, 2009).

Such surfaces need to be used as per the manufacturer's operating instructions to be effective and to avoid causing harm. Clearly, the staff did not adjust the air mattress as per the instructions in the care plan and operation manufacturer's instructions for the mattress to [Ms A's] weight as her weight reduced. However, without regular weighing staff did not have an accurate weight for [Ms A] on which to make decisions about the pressure of the air mattress.

In summary, it is my opinion that the air mattress was operated as per the instructions in the care plan and operation manufacturer's instructions. However, without regular weights staff were unaware that the pressure needed to be adjusted. This would have increased the risk of developing and the worsening of the pressure ulcer as the air mattress would have been too hard. In addition, the Roho cushion appeared to be missing for the month of [Month7].

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Nutrition and hydration
The underlying reason(s) for [Ms A's] poor appetite, nausea, and weight loss were not identified or addressed. If they had been, the pressure ulcer may not have developed or may have healed. In my opinion, [Ms A's] restricted-calorie diet should have been discontinued as early as [Month4] and her food and fluid intake closely monitored. The dietician did commence Fortisip to increase protein intake at the end of [Month8] but there was a delay in getting it due to the need for a special order number. Significant loss of appetite, weight loss, and poor nutritional and fluid intake such as that experienced by [Ms A] increase the risk of pressure ulcers and delay wound healing.

Monitoring of vital signs
[Ms A] died from septicaemia. It is apparent from the documentation provided that [Ms A] had an infection as early as 1 [Month9] 2010 evidenced by an elevated temperature, increasing wound exudate and odour, increasing pain, deteriorating general health and increasing confusion. [Ms A] had an elevated temperature on 3 [Month9] 2010. Her temperature was normal on 4 [Month9] 2010. No vital signs were recorded after this date until 12 [Month9] 2010.

In my opinion, the RNs should have monitored [Ms A's] vital signs frequently e.g. twice to four times a day while there was evidence of the presence of infection (criteria in section D3). This may have assisted in identifying the seriousness of, and the spread of infection at an earlier stage. Ongoing and regular monitoring of vital signs would have indicated if the antibiotic therapy was effectively treating the infection. However, the GP did see [Ms A] on the 9 [Month9] 2010 when she was clearly unwell, did not request regular monitoring of vital signs, and did not change her treatment or seek specialist advice.

Systems failures
In my opinion, there were numerous systems failures.

1. The enrolled nurse appears to have been responsible for [Ms A's] care on some days. In my opinion, [Ms A] was a complex patient and her weight loss indicated that she might not have [been] clinically stable at times. I question whether an enrolled nurse should have been managing her care. I note that RNs provided oversight and RNs contributed to her care management.

2. In a facility the size of St Joans Hospital the day-to-day management of the care of residents would be the responsibility of the RN(s) and the EN on duty. It is clear from competencies for these staff as set out in Section C of this report that the RNs had a responsibility for the assessment, care planning, and evaluation of care along with direction and delegation of care. The facility and clinical managers could expect that this was occurring. There is evidence that the RNs (other than the facility and clinical managers) were the main contributors to the care plans.

3. I note that the orientation check list for RNs and ENs does not specifically cover some of the above nursing practices e.g. comprehensive assessment,

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direction, and delegation. Furthermore, other health professionals would be expected to meet the competencies for their professions. No information has been provided as to their responsibilities when attending residents at St Joans.

4. It appears that the level of orientation that could have been reasonably expected by new senior nurses was not provided. No evidence has been provided that an orientation checklist was completed.

5. There was a personnel change in the senior management positions within 2010. Stability of leadership in this setting supports better quality of care and particularly reducing the presence of pressure ulcers (Castle & Lin, 2010; Rantz et al., 2003; Whitehead, [RN C], Rouse, Robinson, & Harrison, 2012).

6. [Ms A] suffered nausea, sometimes vomiting and a poor appetite. Her weight loss was significant. The underlying reason(s) for this was not confirmed. It appears that these symptoms were attributed to her behaviour. I note that the report dated 14 [Month9] 2010 stated that while [Ms A] presented with challenging behaviours she had not presented with maladaptive behaviour. Further on in this letter the author of the letter (a consultant psychiatrist) did not concur that there was a significant behavioural element to [Ms A's] current health status.

7. I found little evidence that the GP reviewed medications regularly to assess whether any of the medications were likely to be causing the nausea, vomiting, diarrhoea, loss of appetite, and weight loss. The GP reviewed blood levels for Epilim and Dilantin. However, other prescribed medication may have been contributing to her symptoms of nausea, vomiting, loss of appetite, and weight loss. I note that the GP only recorded [Ms A's] blood pressure [in late 2009]. In 2010, [Ms A's] blood pressure was at times much lower than would be expected, <110 systolic. I question why there is no evidence that her hypertensive therapy was reviewed. The low blood pressure could have contributed to poor tissue perfusion and increased the likelihood of skin breakdown.

8. [Ms A] remained on a strict diet prescribed by a dietician until [Month8] 2010 even though she achieved her goal weight. The dietician discontinued a nutrition supplement prescribed by the GP in [Month4] 2010. If continued and/or a high protein diet prescribed it may have contributed to better nutritional intake and less likelihood of weight loss and skin breakdown.

9. It appears that a request for a pressure-reducing mattress in [Month5] 2010 was not met. An air mattress was finally provided by the organisation in [Month7]. A senior staff indicated that she felt that there were restrictions related to financial controls limiting the availability of such equipment.

10. It appears that the weighing scales were not functioning properly and that this was not addressed with urgency. This resulted in [Ms A] not being weighed regularly during a period ([Month6] and [Month7] 2010) when she appears to

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have lost a significant amount of weight. This contributed to the air mattress pressure not being set to [Ms A's] actual weight from the time it was put in place.

11. [Ms A] had a mental health condition. The health professionals caring for [Ms A] attributed many of her complaints to this condition. It appears that this may have occurred without effectively ruling out all physical health issues in the case with the weight, nausea, and vomiting.

12. It appears that there may have been an uneasy working relationship between the RNs and the GP as described by [RN D]. Furthermore, [RN D] also states that the 'GP always felt that [Ms A's] problems were behaviour related'. [RN D] claims she 'did not have confidence in his approach or abilities re patient care'. It appears that [Ms A's] family also had issues with the GP's interactions with them.

13. The progress notes record numerous days where two hourly turns were completed. No evidence has been provided of the detailed documentation of repositioning [Ms A] that [RN D] stated were kept each shift. Further, the GP stated that [Ms A] refused to allow the staff to change her position regularly although this was infrequently reflected in the nursing progress notes.

14. There was only one incident form provided for the development of a pressure ulcer although there were reports in the progress notes of new broken areas. This brings into question whether there were adequate systems in place for the monitoring of adverse outcomes of care.

Conclusions

[Ms A] developed a pressure ulcer while in the care of St Joans Hospital. She had a number of risk factors that contributed to this. [Ms A] had a mental health condition that would at times have seen her non-compliant with care and staff requests, her general health was deteriorating due to long-standing nausea, loss of appetite and vomiting, which in turn resulted in poor food intake over the time in question. On arrival at [the public] Hospital, [Ms A's] malnutrition was confirmed and [Ms A] died of septicaemia.

There were multiple systems failures as documented in Section 5. In addition, in my opinion there were failings by the GP, dietician, nursing staff, the manager, and the organisation. The failings were interlinked and it is difficult to apply the standards separately. It is my opinion that [Ms A's] care did not meet the following standards:

1. The requirements of acceptable standards of care required by NZS 8134.2:2008 standards set out in section A 1 to 5 of this document.
2. The competencies for the registered nurse as set out in Section 2 C of this document.
3. The requirements of the Age Related Service provider agreement as set out in Section B 1,2,3,4, and 7.

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In my opinion the departures to provide care to meet [Ms A's] needs contributed to the development of the pressure ulcer, the deterioration of the pressure ulcer and ultimately to her death. These departures would be considered moderate to severe by peers.

Section 6
Section 6 considers the actions of individual staff members and the organisation as requested. Numerous systems failures had been identified. These have been taken into account when considering the actions of the following individual staff members.

[RN D]
[RN D] commenced employment in [Month8] 2010, approximately four weeks before [Ms A] was transferred to acute care and after the pressure ulcer developed. [RN D] took booked leave in [Month9] 2010 (dates not provided but possibly from the 10th). [RN D] stated that she was unaware of quality issues at the facility when accepting employment. Much of [RN D's] time would have been taken up with orientation and getting to know the residents and staff with little time to make improvements. Furthermore, many of the issues identified below were influenced by systems failures.

Standard of nursing assessment and care provided
In my opinion, from the time [RN D] commenced working at St Joans in [Month8] 2010 until 12 [Month9] 2010 the care of [Ms A] was inadequate in the following areas:

1. ongoing monitoring of health status;
2. pain management;
3. food and fluid intake;
4. the lack of a turning regime in the care plan;
5. timely commencement of prescribed antibiotic therapy;
6. availability of recommended wound care products; and
7. incorrect pressure in the air mattress.

Care planning
From the time [RN D] commenced working at St Joans in [Month8] 2010 the care plans (long and short term) were of an acceptable standard to ensure pressure ulcer management apart from detailing the turning regime. A turning regime should have been included in the care plan well before [RN D] commenced employment. Furthermore, the RNs/EN could be expected to ensure that the long-term care plan was reviewed at the same time the short-term care plan was written on 3 [Month9] 2010. [RN D] should not have needed to undertake this personally as there were registered nurses on duty at all times who had a responsibility to ensure the care plans were current. However, I would expect that, as [Ms A] was clinically unwell that [RN D] had clinical oversight. Following the dietician's visit on 31 [Month8] 2010 a review of the nutrition and hydration plans were completed. There were pain and wound care assessments/care plans in place.

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In my opinion, there is little evidence that [RN D] contributed to the deterioration of the pressure ulcer through her actions or lack of action in relation to care planning.

Pressure ulcer prevention/management
The pressure ulcer had already developed by the time [RN D] commenced employment. In addition, there were a number of systemic factors affecting [RN D's] ability to ensure appropriate care was provided to [Ms A] such as her being newly employed to the facility in [Month8] 2010. In my opinion, [RN D's] actions or lack thereof had no impact on the development of the pressure ulcer.

The pressure ulcer management from [Month8] 14th (around the time [RN D] commenced employment) was managed in an acceptable manner. The GP was notified when the wound appearance changed indicating infection was present. The GP reviewed the pressure ulcer on the 2 [Month9] 2010 and 9 [Month9] 2010. The GCNs reviewed the management twice. It appears that [RN D] was on leave following the GCNS visit on 9 [Month9] 2010 so would not have been able to follow up on the wound care products prescribed.

In my opinion, there is little evidence that [RN D] contributed to the deterioration of the pressure ulcer through her actions or lack of action.

Air mattress
St Joans Hospital had a plan in place for the monitoring of the air mattress prior to [RN D] starting her employment there. Whether [RN D] was made aware of this, I cannot determine. [RN D] had the overall clinical responsibility to ensure the air mattress was set at the correct pressure. Staff weighed [Ms A] on the 23 [Month8] 2010 for the first time since [Month5] and little more than one week after [RN D's] commencement date and during what should have been orientation time. The following week the GCNS identified that the pressure of the air mattress was an issue. The EN/RNs who managed [Ms A's] care on a day-by-day basis should have advised [RN D] of the magnitude of the weight loss and adjusted the air mattress. There is no evidence that this occurred.

In my opinion [RN D] could not have been expected to know the resident well enough to identify the problem of weight loss and address the pressure in the air mattress.

Documentation of care
I can find very few entries in the clinical record that I can attribute to [RN D]. It appears that the RNs/EN documented the care of [Ms A] as would be expected in a facility of this size. [RN D] was responsible for the standard of the documentation. I found the documentation of care provided a reasonable picture of [Ms A's] progress. Food and fluid intake records were kept at the request of the Dietician from the beginning of [Month9]. Pain assessment records were kept, as were records of the wound care from the time of [RN D's] employment. However, the care plan lacked detail of suitable turning regime and no detailed turning charts

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have been provided. I doubt [RN D] had been employed long enough to identify gaps in policies, procedures, practices, and address them.

In my opinion, [RN D] could have expected the EN/RNs to update care plans, monitor both food/fluid intake, and keep records of the position changes. [RN D], as the clinical manager, was expected to have clinical oversight. Given [RN D] was new to the role and the numerous systems failures, there is little evidence that [RN D's] oversight of the documentation of care was responsible for the gaps in documentation.

Personal care needs
There is minimal evidence that [Ms A's] personal care needs were not being consistently met when she allowed staff to provide care to her. There was an incident where the facility manager addressed care that was not provided at the correct time with the relevant staff.

Nutrition/weight loss
[Ms A's] appetite continued to be poor. The GP was aware of this. An additional visit by the dietician was initiated at the end of [Month8] 2010. [RN D] did not start her employment until [Month8] 2010. The lack of weights and significant weight loss prior to this date cannot be attributed to her clinical oversight of [Ms A].

As already stated, food/fluid charts were kept from the time the dietician requested them. The next monthly weigh, as ordered by the dietician, was not due until later in [Month9] 2010. The evidence is that the staff were diligent in offering [Ms A] a range of soft food and prescribed supplements. [Ms A's] poor appetite, weight loss, and malnutrition (as evidenced by the Laboratory report of the 10 [Month9] 2010) were mostly likely the result of systems failures, and the actions or lack thereof of other health professionals previously identified rather than [RN D's] clinical oversight.

Obtaining and sending specimens to the laboratory
After [RN D] commenced employment the collection of laboratory specimens, as ordered by the GP, were collected within a reasonable period.

Communication with the family about care
There are adequate records of communication kept by the RNs/EN with the family. [RN D] missed a care review as the result of planned leave. The facility manager attended the care review in her place. It is my opinion that the GP should have discussed [Ms A's] deteriorating condition with the family following his visit on the 2 [Month9] 2010 and 9 [Month9] 2010 rather than it being the responsibility of the nursing staff. In my opinion, there is little evidence that [RN D] contributed to a lack of communication with the family/welfare guardian.

Anything else
The ongoing monitoring of [Ms A's] condition via vital signs once her condition and the GP indicated that the wound was infected did not occur. However, the GP

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did review [Ms A] on 2 [Month9] 2010 and 9 [Month9] 2010 and did not request such monitoring. It is my opinion that [RN D], as part of clinical oversight of [Ms A's] care, should have ensured the continued monitoring of vital signs once [Ms A] had been commenced on antibiotics, had elevated temperatures, a deteriorating wound. [Ms A's] general health was deteriorating (as recorded by the staff) and she presented with increasing confusion. This is expected nursing practice as per nursing competencies set out in Section 2: C1, C4, and C6. It appears that [RN D] may have been on leave from 10 [Month9] 2010.

Considering all these factors, my opinion is that [RN D's] peers would consider this a moderate departure from expected practice.

Based on the information in the food charts and the progress notes, [Ms A] was under-hydrated and probably dehydrated. [RN D] had a responsibility during the time of her employment to have clinical oversight of [Ms A's] fluid intake. I can find no evidence that the RNs/EN or [RN D] raised the issue of [Ms A's] poor fluid intake with the GP. Monitoring and ensuring adequate fluid intake is expected nursing practice as per nursing competencies set out in Section 2: C1, C4, and C6. It is also an expected standard of care (Section 2: A5).

My opinion is that [RN D's] peers would consider this a moderate departure from expected practice.

Based on the information in the pain charts, the wound care records and the progress notes, [Ms A] was in pain that was not relieved by the medications prescribed routinely and p.r.n. The RNs/EN recording the presence of pain would be expected to administer p.r.n. medications. The p.r.n. medication (paracetamol) was not given on some occasions when pain was documented. In addition, there are some occasions when [Ms A] refused pain relief. In addition, there is little evidence that the effectiveness of p.r.n. pain relief was evaluated. [RN D] was expected to provide oversight of pain management (Section 2: C6).

The GP, in his responses, acknowledged that he was aware that [Ms A] was in pain but was reluctant to prescribe morphine. In my opinion, given the prescribed pain management regime for [Ms A's] pain, [RN D] would have been unlikely to ensure that [Ms A's] pain was maintained below her pain threshold.

In my opinion, the prescribed pain relief regime and [Ms A's] refusal to take medication offered were more likely to have contributed to the pain experienced by [Ms A]. In relation to [RN D's] clinical oversight, [RN D's] peers would consider this a mild departure from expected practice.

The GP prescribed an antibiotic orally for [Ms A] on 2 [Month9] 2010. The first dose of the antibiotic was signed for at 0700hours on 3 [Month9] 2010. [Ms A] had an elevated temperature on 2 [Month9] 2010 reinforcing the need have the prescribed antibiotics. The RNs/EN on duty at the time were responsible for administering and signing for medications. There are barriers to medication being commenced promptly in residential care facilities such as having to send the

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prescription to the offsite pharmacy and for the pharmacy to deliver the medication. Because of this most aged care facilities keep a small bulk supply of antibiotics to avoid delaying commencement. [RN D] had a responsibility as clinical manager to ensure that the supplies were in place so the antibiotic was commenced promptly (Section 2:B6). Due to the short tenure of [RN D's] employment at this time, she may not have been orientated to the medication management system. Furthermore, the facility manager had the overall responsibility to ensure that supplies were available (Section 2: B6 and B9).

In my opinion, the failure for prompt commencement of the antibiotic was most likely related to systems failures rather than the actions or lack thereof of [RN D].

[RN C]
[RN C] was the Clinical Manager at St Joans Hospital during 2010 up until the 6 [Month8] 2010. I will address [Ms A's] care up to this date. Many of the issues identified below were influenced by systems failures. I will discuss these as they apply to [RN C] in the following sections.

Standard of nursing assessment and care provided
The clinical records provided to me demonstrate that in the main, there was ongoing nursing assessment of [Ms A's] condition and issues identified were communicated to the GP in a timely manner. In my opinion, during [RN C's] employment, the care of [Ms A] was inadequate in the following areas:

1. pain management
2. food and fluid intake and the monitoring thereof
3. lack of a turning regime in the care plan
4. lack of monthly weights
5. lack of pressure reducing surfaces prior to [Month7] 2010
6. Absence of the Roho cushion in [Month7]
7. Correct pressure in the air mattress; and
8. lack of a wound assessment and care plan from 2 [Month7] 2010 until end of employment.

Care planning
All [Ms A's] care plans were reviewed and updated in [Month5] 2010 and further updated after this time. During [RN C's] employment the care plans were, in the main, of an acceptable standard. The exceptions were a turning regime once [Ms A] was longer turning herself, the use of pressure reducing surfaces prior to [Month7] 2010 and there was no care plan for the grade two pressure ulcer that was reported from 2 [Month7] 2010 until [RN C's] termination of employment. This should not have needed [RN C] to undertake this personally. The RNs/EN could be expected to ensure that the care plans were current. As [Ms A] was clinically unwell, [RN C] was required to have oversight of her care.

In my opinion, [RN C] contributed to the deterioration of the pressure ulcer through her lack of clinical oversight of the care planning. Her peers would consider this a moderate failure.

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Pressure ulcer prevention/management
The pressure ulcers started developing as early as [Month5] 2010. Several factors contributed to the development of the pressure ulcers.

There was no detailed turning regime in the care plans. The care plan indicated that [Ms A] was able to turn herself. However, the progress notes indicated that this was not the case. [RN C] states that a turning regime was implemented. There is enough evidence in the progress notes to reassure me that the staff were aware that [Ms A] needed turning two hourly. In addition, [RN C] states that the turns were documented on a turn chart. No turn charts have been provided.

The Roho cushion (a pressure reducing surface) appeared to have been missing for the month of [Month7]. The physiotherapist was aware that it was missing in early [Month7] and had a responsibility to follow this up, as did the RNs/EN. Although [Ms A] was not up in her chair a lot, when she was this may have contributed to the development and deterioration of the pressure ulcer.

In [Month5] 2010, [Ms A] had broken areas, was at very high risk for developing pressure ulcers and not eating well. The use of a suitable pressure-reducing surface should have been implemented when the care plan was reviewed in [Month5] or even as early as [Month2] 2010. [RN C] states that when an air mattress was requested one was not available in the facility.

When the pressure ulcer developed in [Month7] 2010, no assessment or care plan was written for the period 2 [Month7] 2010 to 14 [Month8] 2010. [RN C] could have expected that the RNs/EN completed this but she had clinical oversight and therefore should have checked that it was done. The lack of a care plan may have contributed to the deterioration of the wound.

[Ms A] continued on low fat diet from [Month5] to [Month7] on the instruction of the dietician. This did not support [Ms A] having a high protein intake as per the guidelines for prevention of pressure ulcers.

Staff did not weigh [Ms A] in [Month6] and [Month7] 2010. Therefore, there was a risk that the air mattress may not have been at the correct pressure for [Ms A's] actual body weight.

In my opinion, there is evidence that [RN C's] actions or lack thereof contributed to the development of the pressure ulcer. Her clinical oversight did not meet the required competency for RNs (Section 2: C6) or the required standards (Section 2: B7, B9, B10 (iii) and Section 2: A1). However, [RN C's] ability to meet the standards and competencies was affected by the systems failures (documented in Section 5). In my opinion, [RN C's] peers would regard this as a moderate departure.

Air mattress
[RN C] had a plan in place for the monitoring of the air mattress as reported by [RN C] in her response to this complaint. [Ms A's] last known weigh recorded in

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[Month5] 2010 was 95kg. The mattress pressure was set for this weight. [RN C] had left employment by the time the extent of [Ms A's] weight loss was known in late [Month8] 2010. The fact that [Ms A] was eating poorly should have alerted the RNs/EN and [RN C] to the need to monitor [Ms A's] weight closely and ensure the mattress was kept at the correct pressure. A systems failure — the scales not working — precluded this from occurring. [RN C] did have some responsibility to ensure necessary equipment was functional. The inability of staff to weigh [Ms A] due to equipment failure contributed to the air mattress being at the incorrect pressure. [RN C] had the clinical responsibility to ensure the air mattress was set at the correct pressure. However, the weighing scales were not functioning. The ultimate responsibility for ensuring the weighing scales were working was the facility manager.

In my opinion, the management of the air mattress did not meet the required standard set out in Section 2: B7. Considering the above and the systemic failures set out in Section 5 and [RN C's] actions or lack thereof contributed to the air mattress not being maintained at the correct pressure for [Ms A's] actual body weight. [RN C's] peers would consider this as a minor to moderate departure.

Documentation of care
It appears that the RNs/EN documented the care of [Ms A] as would be expected in a facility of this size. [RN C] had clinical oversight (competency as set out in Section 2: C6) for the standard of the documentation. I found the documentation of care provided a reasonable picture of [Ms A's] progress. [RN C] could have expected the EN/RNs to detail progress, update assessments and care plans, monitor both food/fluid intakes, record the position changes and communication with the family (competencies as set out in Section 2: C1–5). [RN C] some made entries in the progress notes and in the care plans.

The gaps identified were the lack of detailed turning charts, food and fluid intakes, and records of the wound assessment and care. Mostly these matters were documented in the progress notes or in the evaluation of the care plans. In my opinion, [RN C's] peers would consider that this was a minor departure from expected practice.

Personal care needs
In my opinion, there is minimal evidence that [Ms A's] personal care needs were not being consistently met when she allowed staff to provide care to her. There was one incident where the facility manager addressed care that was not provided at the correct time with the relevant staff.

Nutrition/weight loss
[Ms A's] appetite was poor. The GP was aware of this. The dietician saw [Ms A] three monthly with an additional visit at the end of [Month8], 2010. Staff were diligent in offering [Ms A] a range of soft food and prescribed supplements. [Ms A's] poor appetite, weight loss, and malnutrition (as evidenced by the Laboratory report of the 10 [Month9] 2010) were most likely the result of systems failures,

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and the actions or lack thereof of other health professionals previously identified rather than [RN C's] clinical oversight.

Obtaining and sending specimens to the laboratory
Requested specimens were collected in a timely manner with the exception of an MSU in [Month5] 2010 and another in [Month7] 2010. [Ms A] was incontinent and was non-compliant. This made collecting urine samples difficult. [Ms A] refused to be catheterised for obtaining a urine sample. Under the circumstances it is my opinion there is little evidence that [RN C] was responsible for the delays.

Communication with the family about care
There are adequate records of communication kept by the RNs/EN with the family. In my opinion, there is evidence that [RN C] and other staff communicated with the family/welfare guardian.

Anything else
Based on the information in the progress notes, [Ms A] was under-hydrated and probably dehydrated from [Month4] 2010 when she was given subcutaneous fluids to address her poor fluid intake. For a short time in [Month4] fluid balance charts were kept. Staff were requested to keep [Ms A] on a fluid chart until her intake improved. This does not appear to have occurred. I can find no evidence that the RNs/EN or [RN C] raised the issue of [Ms A's] poor fluid intake with the GP. Monitoring and ensuring adequate fluid intake is expected nursing practice as per nursing competencies set out in Section 2: C1, C4, and C6. It is also an expected standard of care (Section 2: A5). [RN C] had a responsibility to have clinical oversight of [Ms A's] intake.

My opinion is that [RN C's] peers would consider this a moderate departure.

[RN E]
[RN E] commenced her employment as facility manager in [Month3] 2010. She described her orientation as being inadequate. [RN E] held the overall accountability for ensuring the needs of the residents were met (Service provider agreement as described in Section 2 B 9 of this document and the position description provided). The oversight of clinical care of the residents was delegated to the clinical manager. [RN E] has a responsibility to ensure that equipment including pressure relief (including mattress and seat cushions), and sufficient clinical equipment was available for general use including weighing scales (as set out in Section 2: B7 and wound care products Section 2: B6). In addition, [RN E] was responsible for ensuring the NZS 8134.0:2008 Health and disability services (general) standards (as set out in Section 2: A) were met.

Did [RN E], as Facility Manager, take appropriate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Ms A]?
[RN E] had the overall responsibility for the standard of care provided to [Ms A] (Section A and B of this report). It was reasonable for [RN E] to expect that the RNs/EN, the clinical managers, and the other health professionals were providing the care that [Ms A] required within their respective scopes of practice and

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meeting the required competencies. There is evidence that [RN E] had some degree of oversight of [Ms A's] care (e.g. she made a referral to the GCNS for wound care advice and review by the dietician at the end of [Month8]). However, [RN E] did not ensure:

- suitable pressure-reducing surfaces available when first requested
- the weighing scales were working correctly
- that there was a system in place for the prompt commencement of the antibiotics once prescribed; and
- was not prompt in providing the wound care products prescribed by the GCNS on 9 [Month9] 2010.

In my opinion these departures contributed to the development and deterioration of the pressure ulcer, the deterioration of the pressure ulcer and ultimately to [Ms A's] death. These departures would be considered moderate to severe by peers.

Did [RN E] communicate appropriately with [Ms A's] family about her care?
There is evidence that, overall the communication between the facility and [Ms A's] family/welfare guardian was adequate.

Is there anything else [RN E] should have done in the circumstances?
There were numerous systems failures in this case. In my opinion, it is difficult to attribute them solely to [RN E's] management of the facility.

Radius St Joans Hospital

Were there adequate clinical governance and quality structures in place at Radius St Joans?
It is difficult to assess in detail the clinical governance and quality structures that were in place. However, with the numerous systems failures identified it appears that they may not have been adequate. Further evidence of this was the lack of incident forms for each of the pressure injuries as they occurred. I am unable to comment further on this matter.

Were [RN D], [RN C], and [RN E] adequately supported?
In my opinion, orientation of new senior staff was inadequate. It appears that there were organisational barriers to accessing pressure reducing equipment and getting equipment repaired within an acceptable timeframe. There were numerous systems failures. It is possible that better clinical governance and quality structures may have identified these systems failures. Senior staff turnover was 100 percent over the time that this complaint occurred. It is my opinion that [RN D], [RN C], and [RN E] were not adequately supported. In my opinion, St Joans Hospital's peers would consider this a serious departure.

Recommendations for improvement
I would like to make the following recommendations:

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1. All the systems failures be reviewed by Radius St Joans Hospital parent organisation.
2. All pressure injuries should be reported via the incident reporting system and be reported as part of clinical governance and quality structures.
3. All policies and procedures should be evidence based using the most current and relevant sources of evidence (some references are more than 10 years old).
4. The management of clinical equipment is reviewed to ensure that it is functional at all times.
5. Review the monitoring of fluid intake and implement a system for targeted intakes for residents at risk of dehydration.
6. Ensure that enrolled nurses work within their scope of practice and they are effectively directed by an RN.
7. Review the position descriptions of the facility manager and clinical manager to ensure that the differences in their responsibilities are clearly stated.
8. Review the orientation provided to facility and clinical managers and ensure they are well supported during the first month of their employment.
9. Review the communication systems between the RNs and the GP.
10. Ensure that there are standards of practice for contracted health professionals and these are monitored as part of clinical governance.

It is acknowledged that some improvements had already been made such as the review of pressure injury prevention.

Noeline Whitehead
Professional Advisor

Reference list [removed for brevity]"

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Appendix B — Expert clinical advice

The following expert advice about the standard of care and treatment provided to [Ms A] by Dr F was obtained from HDC's advisor, general practitioner Dr David Maplesden:

"[Background to complaint removed for brevity.]

3. Response from [Dr F]

(i) [Dr F] took over [Ms A's] care from [late] 2009. He provides 24-hour cover for RSJ [Radius St Joans Hospital].

(ii) [Ms A] had a past history of subarachnoid haemorrhage [at age 38 years]. This had left her with left sided paralysis and cognitive and visual impairment. She also had a longer history of depression and borderline personality disorder which [Dr F] states *would certainly explain a lot of her difficult and unfortunate self-destructive behaviour*. There were additional diagnoses of post-stroke seizures, development of morbid obesity, and chronic anxiety.

(iii) [Ms A] was assessed by neuropsychologists and psychiatrists while in RSJ (see clinical notes review). One such report *outlines* [Ms A's] *lack of adherence to nursing and dietary management plans over a long period. The letter* [dated 5 May 2009] *also details that* [Psychiatrist Dr I] *talked to [Ms A's] mother and Welfare Guardian at the time about alternative hospital placement if [Ms A] was not interested in modifying her behaviour, and this suggestion was not acted on.*

(iv) [Dr F] has provided a transcript of his interactions with [Ms A]. He notes she was a *complex and very difficult personality to deal with…a poor historian, often declined to answer questions…tendency to cancel outpatient appointments at the last minute…any physical symptom had to be filtered through the possibility that it could well be behavioural in origin. Most of the time I proceeded to investigate these for physical causes, rather than dismissing them as behavioural as I am accused of doing.* He illustrates some of these points with reference to the investigation and management of [Ms A's] complaints of abdominal pain in late 2009 and early 2010.

(v) [Dr F] describes [Ms A's] presentation with incoordination of her right (previously unaffected) side in early [Month4] 2010. He wanted a CT scan to determine whether the new symptoms were in fact stroke related or behavioural and made referrals to both neurology and psychiatric services, neither of which agreed to undertake the scan initially, instead deferring to each other. When the scan was finally performed, it did not show any radiological evidence of recent stroke. [Dr F] comments that at the time the family were requesting [Ms A] be admitted to hospital (see 2(iv)) *the primary reason for doing so would have been her lack of cooperation with eating, drinking and turning* in addition to the pressure area, and he felt request for an admission would have been turned down

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by the relevant hospital registrars. *In hindsight it is regrettable the family and I did not have further contacts about their ongoing concerns.*

(vi) [Dr F] first viewed [Ms A's] sacral pressure area on 16 [Month8] 2010. He rechecked it on 26 [Month8] and 2 and 9 [Month9] 2010. Viewing involved coordination with nursing staff because of [Ms A's] obesity and the use of long-term dressings. *I was told [Ms A] would not cooperate with the staff's attempts to regularly reposition her to take pressure off the sacral area. She was also eating and drinking poorly, needing to be fed and often apparently declining to eat*. A dietetic assessment was arranged to improve protein intake and aid the healing of [Ms A's] ulcer. [Ms A] was also referred to the Community Wound Care Specialist Nurse for an opinion and advice as is normal practice for such pressure areas at RSJ. There was no sign of infection in the ulcer until review on 2 [Month9] 2010 when *local infection in the surrounding tissue* was noted and a one month course of flucloxacillin commenced. [Dr F] states *I last saw the pressure ulcer on Thursday the 9th of [Month9], and I did not think at that time she needed urgent admission for surgical debridement, or for her local infection*. [Dr F] was contacted by RSJ in the early hours of 12 [Month9] 2010 to be told [Ms A] was unwell and had a temperature. He advised she be admitted immediately to [the public hospital], assuming she might have a pneumonia as she was on flucloxacillin. [Dr F] did not consider it likely the cause of her unwellness was the ulcer. He regrets, in retrospect, not arranging admission for assessment and possible surgical debridement of [Ms A's] ulcer on 9 [Month9] 2010 although the decision not to admit her was *made thoughtfully and to the best of my ability at the time…I do understand from talking to the nurses and caregivers that [Ms A's] ulceration progressed rapidly over the last few days, but that does not change the fact that the responsibility is ultimately mine.*

(vii) [Dr F] notes the difficulties encountered gaining additional help and expertise for [Ms A] given her relatively young age. She was not eligible for services from the Older Peoples Health service who would normally provide an on-site general assessment and advice or admission for the residents of aged care facilities such as RSJ. He states *Because I felt several of the contributing factors to her lack of wound healing, such as poor nutrition and refusal to allow regular turning, was behavioural I referred her back to Community Neurobehavioral Services…in the hope they could help her with her lack of motivation to help herself , and in turn her nutrition.* The referral was declined.

(viii) Pain control was an issue because it was difficult *sorting out* [Ms A's] *true level of pain.* [Ms A] gave inconsistent responses to [Dr F's] questions about pain, and sometimes declined to reply at all. He established from her caregivers that pain was mostly associated with her being moved. Pre-existing analgaesia of codeine was doubled in dose on 23 [Month8] 2010 in an attempt to gain better pain control, but [Dr F] was anxious to avoid making [Ms A] drowsy given her pre-existing neurological disabilities and dependence.

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4. Clinical notes:

(i) [Dr F's] notes are consistent with his response. There are consultations approximately every 10 days [for six months] to end of [Month3] 2010. These include multiple consultations related to [Ms A's] complaints of nausea and vomiting which result in a surgical referral after appropriate investigations including blood tests and abdominal ultrasound. The investigations demonstrate a solitary gallstone but the surgeons are not convinced this is the cause of her symptoms and decline surgery. There are also consultations for shoulder pain (referred to orthopaedic surgeons by previous medical officer), treatment for urinary infections, and routine monthly checks. There is no documentation of skin problems over this time.

(ii) Notes for 1 [Month4] 2010 include *lowered mood…denies any physical symptoms other than nausea — check MSU. Visitors suggest possible CVA…can move right arm normally…*On 8 [Month4] 2010 [Dr F] notes contact by SJA staff the previous weekend because of [Ms A's] poor eating and drinking. Subcutaneous fluids were authorised by fax and [Ms A's] drinking apparently improved. Notes include *Today discussed with mother and [Ms H]. [Ms A] eating poorly and very morose with poor cooperation…*[physical examination recorded — limited by [Ms A's] lack of cooperation]*…is this depression…refer neurobehavioral service…?mild CVA with some decrease of co-ordination and strength right side. Poor co-operation from [Ms A] making evaluation very difficult…?has got a cholelithiasis or gall bladder abscess* [blood tests arranged and antibiotics commenced]*…to evaluate after blood tests.* Reviews on 12 and 15 [Month4] 2010 indicate possible slow recovery *from apparent…minor CVA — better arm/hand coordination and can feed self with help. Claims loss of vision in right eye after ?CVA. Visual fields today NAD and able to read print despite claiming cannot.* A referral is sent for neurologist review in the hope a CT scan will be obtained to confirm the diagnosis of possible recent new stroke.

(iii) There are ongoing reviews every 7–10 days for a variety of problems and routine checks. Documentation in [Month5] 2010 notes the difficulty [Dr F] is experiencing getting a CT scan performed on [Ms A]. On 13 [Month5] 2010 *Poorly communicating. No CHF or dehydration.* On 27 [Month5] 2010 [Ms A] is reviewed after falling from her wheelchair and sustaining a forehead laceration. On 17 [Month6] 2010 investigations are undertaken because of ongoing loose bowel motions, and on 28 [Month6] 2010 treatment for a culture-proven yeast related skin condition is given (manifest as axillary rash). On 15 [Month7] 2010 swabs are taken after [Ms A] complains of a vaginal discharge and these are normal. On 28 [Month7] 2010 a referral is made for orthotic splints to treat a flexion contracture in [Ms A's] left arm. There is no mention of a pressure area until 16 [Month8] 2010.

(iv) On 16 [Month8] 2010 notes record *Monthly check. Medically stable. Rash L axilla — swab. Rx Micreme cream* [previous swab had grown candida]. *Pressure area deeper. No infection — regular repositioning in bed.* On 26 [Month8] 2010 *Check of pressure ulcer — buttock cleft. Not infected. Sloughy. Not currently on*

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antibiotics… No specific care instructions are noted at this consultation. On 2 [Month9] 2010 *Sacral pressure area has minor local infection. Swab done — Rx Fluclox one month. Dietitian has seen her → applying for Fortisip…*On 9 [Month9] 2010 *declining to eat much food — says she has an allergy to food. Starting on Fortisip after dietetic assessment. Pressure area not improving. No infection. Repeat bloods and antiepileptic drug levels to r/o side effects from drugs (making her drowsy and uncooperative)…refer back to Community Neurobehavioral Service for assessment re difficulty feeding.*

(v) I could find no result for the wound swab taken on 2 [Month9] 2010 although a urine sample taken at the same time was clear of infection. The blood tests from 10 [Month9] 2010 did not show any toxic levels of the anti-epileptic agents [Ms A] was taking. Blood count showed a progressive drop in haemoglobin since the test of 1 [Month9] 2010, although there was no elevation of white cell count or neutrophils to suggest a systemic response to infection. There was no evidence of diabetes. Serum ferritin was elevated suggesting current inflammation. Serum proteins were decreased which could be consistent with sub-optimal nutrition.

(vi) Neuropsychological assessment dated 1 October 2003 confirms a longstanding history of depression. She has a left visual field defect since her stroke in addition to a significant refractive vision (keratoconus) problem which worsens as the day progresses. Neuropsychological testing indicates significant global deterioration from her pre-stroke level of cognitive functioning especially with regards to processing information. Neurology assessment dated 26 July 2004 notes *a long history of borderline personality disorder* and questions [Ms A's] compliance with her anticonvulsant medication. Psychiatrist assessment dated 2 July 2008 ([Dr O]) notes [Ms A's] complex past psychiatric history and current anxiety symptoms. [Ms A's] spiralling weight gain secondary to an inability *to comply with the dietary plan put in place* is noted. The opinion includes the comment *[redacted for privacy reasons]*

(vii) On 5 May 2009 [Ms A] is reviewed by psychiatrist [Dr I] *[redacted for privacy reasons]*

(viii) [Ms A] is reviewed by psychiatrist [Dr O] [in early] 2009. He notes her chronic dysthymia and discusses the possibility of further cognitive behavioural therapy although it is difficult to access this in the public system (in fact local services, who have treated [Ms A] in the past, decline further contact because *therapy in many forms has been trialled with her and it has been very difficult to engage [Ms A]*). [Dr O] notes [Ms A's] ongoing behavioural difficulties *[redacted for privacy reasons]*

(ix) [Dr F's] referrals to both neurology and neurobehavioural services in [Month4] 2010, and a further referral to neurobehavioural services in [Month9] 2010 are noted. The neurology service declines to see [Ms A] as they *doubt there would be any specific neurological input whatever we find on a CT head scan* and advises neurobehavioral review. However, the neurology service eventually arranges a CT scan (performed on 16 [Month7] 2010) which does not reveal any

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significant changes since a previous scan of 2002. Letter from [Dr I] dated 17 [Month5] 2010 notes [Ms A's] history of a possible new stroke at the end of [Month3] 2010 with some recovery of function but *residual right sided weakness and clumsiness as well as difficulty swallowing and drooling*. Following a limited assessment, [Dr I] suggests [Ms A] has had a left hemisphere lacunar infarct and that physiotherapy and speech and language therapy might be appropriate. In [Dr F's] re-referral to [Dr I] dated 10 [Month9] 2010 he notes the recent negative (for new infarct) CT scan and that *we can only conclude at that time her problem was behavioural…[Ms A] has entered a new phase of difficult behaviour and is now refusing to eat unless fed and is sometimes refusing even this…*[she stated] *she was allergic to food…* [Dr I] replies on 14 [Month9] 2010 noting that a lacunar infarct may not be evident on delayed CT scan, that clinical signs were consistent with such a neurological deficit, and that [Ms A] had never presented with maladaptive illness behaviour previously. *I therefore think there are clear limitations to relying on imaging alone to make this call and I would not concur that there is a significant behavioural element in this.*

(x) Dietitian letter dated 31 [Month8] 2010 indicates long-term involvement with [Ms A], initially to aid in weight loss. On this occasion the letter states *earlier this year [Ms A] experienced problems with nausea and at this time began to refuse some meals. She then appeared to have a further decline in health and was referred for dietary review due to rapid weight loss. I observed [Ms A] eating breakfast today and she did well eating a large bowl of porridge. She is currently unable to feed herself so is being fed by staff. Due to [Ms A's] behavioural problems, she needs staff to give encouragement for all oral intake…*

5. Comments on GP management:

(i) [Ms A] was clearly a complex patient to diagnose and manage and this is consistently borne out in the clinical notes and specialist letters. She had a longstanding history of behavioural difficulties including issues with communication and compliance. These issues cannot be ignored when determining to what degree [Dr F] was able to provide the standard of clinical care he might have provided under less fraught circumstances. I can certainly see no evidence that [Ms A] received inattentive care. Consultations with [Dr F] were frequent and were generally followed up with appropriate investigations and treatment. There was a justifiable basis for considering a behavioural element to many of [Ms A's] presentations — the past medical history is an important factor to take into account when determining diagnosis and management and [Dr F] did this appropriately.

(ii) In retrospect, it appears [Ms A] probably did suffer a cerebral event at the end of [Month3] 2010 and this was, at least in part, responsible for her deteriorating eating (through difficulties with coordination of swallowing and self-feeding) which in turn led to poor nutrition and increased risk of pressure areas. To what extent the cerebral event led to a deterioration in [Ms A's] non-compliance behaviours (including eating) is less clear, and it is possible her deterioration was a consequence of both 'physical' and behavioural elements. [redacted for privacy

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reasons] There was no indication for hospital admission when [Ms A's] possible new stroke diagnosis was first entertained as it had been some time since the event and her condition was stable. The lack of support for [Dr F] from the neurology service is disappointing as a more timely expert neurological assessment and CT scan might have resulted in confirmation of the cerebral event and an altered approach to subsequent management. The 'remote' ordering of the CT scan by neurology services also meant the result was given without a clear clinical context eg the indications for the CT did not specify the nature or even side of the new neurological symptoms. [Dr F] interpreted the CT scan as indicating there had been no new neurological event to account for [Ms A's] symptoms, and therefore they were more likely to be behavioural. However, CT scanning has low sensitivity for detecting lacunes (30 to 44 percent) although its use is mandatory to exclude other potentially life-threatening diagnoses such as intracerebral haemorrhage or subdural hematoma[1]. I would not expect a GP to be aware of the low sensitivity of CT scanning for detecting lacunar infarcts and it was reasonable for [Dr F] to make the assumption he did. I do note that [Dr I] had suspected a lacunar infarct based on his assessment of [Ms A] and had stated this in his letter. It might have been prudent for [Dr F] to have discussed the diagnosis with him once the CT scan result was available, or for [Dr I] to have confirmed with [Dr F] that the CT scan result (copy received by [Dr I] from neurology department) did not exclude the diagnosis. Nevertheless, I do not feel that [Dr F's] belief that [Ms A's] poor eating may have had a behavioural basis represents a departure from expected standards under the complex circumstances described. There was appropriate dietitian involvement. Nursing input is discussed separately.

(iii) General pressure area management is discussed in more detail below. [Dr F's] role was to review the pressure ulcer at a frequency he felt was appropriate based on his impression of the status of the ulcer and on feedback from nursing staff as to its progress. Had there been evidence of infection, antibiotics preceded by swabbing the wound would be indicated and this was done (although I could not find the result of the swab). There is no role for prophylactic antibiotics and there was no indication [Dr F] was aware the wound was infected until antibiotics were commenced on 2 [Month9] 2010. [Dr F] feels the wound deteriorated markedly in the few days after he saw it on 9 [Month9] 2010. Even though [Ms A] was on antibiotics, [Dr F] should have been notified of the deterioration if routine reassessment was not planned and this was the responsibility of nursing staff. [Dr F] should have documented his planned review date although this may have been agreed verbally. The issue of whether surgical debridement was indicated earlier is difficult to comment on as I have not viewed the wound. As [Dr F] has acknowledged, it perhaps should have been considered when there was no progress being made by 9 [Month9] 2010 in spite of antibiotic treatment, although this would depend to some extent on the nature and depth of the ulcer. The fact that the ulcer had involved subcutaneous tissues and muscle by 12 [Month9] 2010 indicates management was sub-optimal and [Dr F] must take some responsibility

[1] Oliveira-Filho J et Kistler J. Lacunar infarcts. Uptodate. Last literature review Month9 2010. www.uptodate.com

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for this as he has stated. It is therefore quite appropriate that he apologise to [Ms A's] family for not considering hospital admission for debridement of the ulcer on 9 [Month9] 2010, although other aspects of his management of the pressure area were consistent with expected standards.

(iv) Management of pain relief for [Ms A] was complex as noted by [Dr F] and he was reliant to some extent on the observations of [Ms A's] carers to direct his prescribing. The medication charts indicate [Ms A] was prescribed PRN paracetamol and this was given intermittently but generally no more often than twice a day in [Month8] and [Month9] 2010. Codeine phosphate was prescribed at 30mg twice daily regularly with the dose increased to 60 mg from 23 [Month8] 2010. Generally, a step-wise approach to pain management is recommended beginning with PRN simple analgesia such as paracetamol, increasing to regular paracetamol then adding stronger agents gradually, titrated to effectiveness and side effects. While it was quite reasonable for [Dr F] to increase the codeine phosphate as he did, it might have been prudent to have [Ms A] on a regular paracetamol dosage in the first instance although it seems likely she would have required the increased dose of codeine in any case. It was appropriate for [Dr F] to consider the side effects pain medication might have on [Ms A's] general wellbeing, as well as the nature and cause of her pain. It seems likely the pain, at least latterly, was related to [Ms A's] pressure area and therefore avoidance of direct pressure over the area was as important as analgesia in providing relief from pain. [Dr F] was reliant on staff reports regarding adequacy of [Ms A's] pain relief and on reviewing the progress notes it does not appear that inadequate pain relief was a major concern documented by them in the latter part of [Ms A's] illness."

Additional advice

"1. I have been asked to provide further comment on the care provided to [Ms A] by [Dr F] in light of concerns raised by the HDC expert nursing advisor in her report dated 22 October 2012. I provided preliminary clinical advice on this case on [25 February 2011], and subsequent comments make reference to this preliminary advice.

2. The nursing expert advice raised concerns that [Dr F] may not have regularly reviewed [Ms A's] medication regime. This concern was raised both with respect to determining a cause for [Ms A's] longstanding nausea, vomiting and poor appetite, and to her more recent episodic hypotension. In general, a casual review of medications is expected at the time of recharting (three monthly) with more formal review undertaken at any time if clinically indicated. Recharting of medications may be taken to imply casual review has taken place even if such review is not specifically recorded in the medical notes. Therefore the absence of reference to medication review does not mean such a review has not taken place.

(i) As noted in section 4(i) of my original advice, [Dr F] investigated [Ms A's] symptoms of nausea and vomiting in a thorough fashion, including surgical and neuro-behavioural referrals and attempted neurological referral. Anticonvulsant levels were checked. I do not think formal reference to considering whether

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medication might have been contributing to her symptoms is a departure from expected standards of care.

(ii) [Ms A] was taking two antihypertensive medications (Inhibace Plus one daily and felodipine 10mg daily). Regular (monthly) routine monitoring of blood pressure was undertaken by rest home staff with readings from [Month1] to [Month8] 2010 ([Month6] reading not recorded) being 109/61, 120/90, 115/80, 110/90, 100/85, 100/65 and 110/65. The [Month6] reading of 100/65 was recorded by [Dr F] in a formal multi-disciplinary review record dated 17 [Month6] 2010. Current blood pressure has been referred to by [Dr F] in his regular reviews of [Ms A] only one additional time — [in late] 2009 (129/80). I would not expect [Dr F] to record routine blood pressure recordings separately in his clinical notes if he was aware the nurses were recording them, and it would be a reasonable expectation that nursing staff would notify him if there were concerns regarding [Ms A's] blood pressure. Readings were generally satisfactory although those from [Month6] 2010 might have indicated a need to review the antihypertensive therapy and perhaps make a dose reduction, although notes do not suggest [Ms A] was symptomatically hypotensive before the end of [Month8] 2010.

(iii) TPR monitoring chart and nursing notes indicate [Ms A] was unwell on 25 [Month8] 2010 with blood pressure recorded as 100/60 then 92/42. On 28 [Month8] 2010 a reading of 92/43 was recorded. [Dr F's] clinical notes of 2 [Month9] 2010 make no reference to [Ms A's] recent hypotensive episodes, and the TPR record and nursing notes indicate antibiotics were prescribed on this day but there are no instructions regarding ongoing monitoring. The TPR chart has been completed again on 3 [Month9] 2010 (118/62 and 110/65) but not again until 12 [Month9] 2010 just prior to [Ms A's] transfer to hospital (90/60). It appears [Dr F] was not notified of [Ms A's] hypotensive episodes, although this was notified to the Clinical Manager. [Dr F] was asked to see [Ms A] on 1 [Month9] 2010 because her wound was deteriorating, and he saw her on 2 [Month9] 2010 (refer to section 4(iv) of my original advice) and prescribed antibiotics. [Ms A's] general condition appeared stable after this until further deterioration in her wound about 9 [Month9] 2010.

(iv) I am mildly critical that [Dr F] did not actively review [Ms A's] blood pressure medication in light of her hypotensive episodes and general unwellness from 25 [Month8] 2010, or direct more intensive monitoring of her blood pressure in light of her general condition. Mitigating factors are that the readings were evidently not brought to [Dr F's] attention by nursing staff (certainly not at the time they were taken), it would be a reasonable expectation that the clinical nurse manager provides appropriate initial advice on the need for monitoring of an unwell patient, and the blood pressure appeared to settle at an acceptable level by 3 [Month9] 2010. Nevertheless, assessment of blood pressure should have been part of [Dr F's] overall assessment of an unwell patient with (at least) local sepsis on 2 [Month9] 2010 (and again on 9 [Month9] 2010, and ongoing regular monitoring of vital signs was indicated until [Ms A's] condition improved.

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(v) I have commented previously on suboptimal aspects of [Dr F's] management of [Ms A's] pressure area (see section 5(iii) of my original advice).

3. The second issue raised by the expert nursing advisor was that of [Dr F's] 'uneasy' relationship with RNs at the facility and that 'the GP always felt that [Ms A's] problems were behaviour related'. These comments were made by one staff member who had been employed at the facility for the month prior to [Ms A's] death. While I acknowledge the perceptions of the staff member involved, and [Dr F] should reflect on these perceptions, it is clearly outlined in my original advice that [Ms A] had complex physical and psychological problems confirmed in previous neuropsychological assessments, and it was reasonable for these aspects of [Ms A's] morbidities to be considered when addressing her current problems. In hindsight, she had probably suffered further neurological damage contributing to the deterioration in her behaviours and general condition and this issue has been addressed in detail in my previous advice.

4. In conclusion, there were some deficiencies in the care offered by [Dr F] to [Ms A] as previously discussed and I feel these were, under the circumstances, generally of a mild nature."

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