

Poor clinical oversight and management of an elderly woman's pressure injuries while in respite care

Executive summary

1. Following a fall at home, Mrs A was admitted to Kumeu Village Rest Home (KVRH) from the local public hospital for respite care on 18 January 2022. The Nationwide Health & Disability Advocacy Service raised concerns on behalf of Mrs A's daughter, Ms B, with the Health and Disability Commissioner (HDC) in relation to a number of issues related to Mrs A's care at KVRH. Sadly, Mrs A died in April 2022. At the outset, I extend my sincere condolences to her whānau for their loss.
2. This investigation focuses on the management of the pressure injuries (PIs) Mrs A suffered while at KVRH. I find Kumeu Village Aged Care Limited in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for failure to provide services to Mrs A with reasonable care and skill in relation to the management of her PIs. I also make an adverse comment in relation to the lack of consideration given to Mrs A's nutritional and fluid intake.

Recommendations

3. Since these events, there has been a change in management at KVRH. The new management team have reflected on the concerns raised by Mrs A's family, and implemented a number of changes and updates to their procedures, including:
 - ensuring senior nurse oversight at the point of admission;
 - mandatory completion of initial risk assessments within 24 hours of admission, covering falls risk, nutritional status, pain levels, skin integrity and cognitive function;
 - a clear escalation pathway for clinical concerns, including following up general practitioner (GP) requests within 24 hours and guidance for when staff should escalate to acute services such as ambulance or accident and emergency;
 - the use of structured communication tools to inform clinical judgements;
 - introduction of the 'Malnutrition Universal Screening Tool', with monthly reassessments and new protocols for identifying and supporting residents at nutritional risk;
 - daily documented skin inspections during personal care and ensuring photographic recording of wounds and PIs at every dressing change;
 - staff training on compassionate and culturally appropriate communication, dementia care, person-centred approaches, and clinical documentation;
 - a clinical communication log to document all communication with families.
4. I acknowledge and support the changes made by KVRH. In addition, I recommend that KVRH:

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- provide a written apology to HDC for forwarding to Mrs A's whānau for the deficiencies identified in this report within **three weeks** of the date of this report; and
- provide HDC with the updated copies of policies and procedures in relation to their admission process, wound management, escalation of care, and communication with whānau within **three weeks** of the date of this report.

Background

Admission to KVRH

5. On 18 January 2022, Mrs A (aged 93 at the time of events) was admitted to KVRH from the local public hospital for respite care following a fall at home on 16 January 2022. The stay at KVRH was intended to be a short-term placement organised by the Primary Options for Acute Care service¹ while Mrs A's family found a long-term care facility for her. Prior to the fall, she had been assessed by the Needs Assessment Service Coordination (NASC) team as requiring private hospital-level care; however, her family had not found a suitable facility. Mrs A's medical history included cognitive impairment, chronic bowel and bladder incontinence, sciatica² and frequent falls linked to functional decline.
6. An admission handover was completed between the public hospital and Registered Nurse (RN) D. RN D developed some initial care plans on the basis of the information provided by the hospital, including personal care, mobility, and communication plans. There is no evidence that Mrs A's nutritional needs were considered or that a nutrition risk screening assessment was undertaken. Mrs A was noted to have some bruising and dressings on her right eyebrow, left forearm, and lower left leg. KVRH told HDC that their usual process would have been for RN D to complete a Norton Score (a scale used to identify the risk of developing PIs) and skin assessment and to take pictures of the wounds. This did not occur.
7. Mrs A became a permanent resident at KVRH on 15 February 2022. This was initially discussed with her daughter on 3 February 2022 because of Mrs A's rapid deterioration but was not confirmed with the care team by administrative staff until 17 February 2022. The local NASC team were not informed of Mrs A's permanent admission to KVRH despite their previous involvement with her. It also does not appear that KVRH requested or received information from the NASC team as part of their admission process, despite the age-related residential care (ARRC) contract (2020) outlining that a needs assessment is required to inform care and service delivery.
8. KVRH's Resident Admission policy (2020) states that an InterRAI assessment should be completed, and a long-term care plan developed within 21 days of admission. A care plan dated 16 March 2022 (over 21 days after Mrs A entered KVRH) was provided as part of HDC's investigation; however, a number of sections, including nutrition status and 'discomfort/pain' are incomplete. It is unclear from the information provided by KVRH whether an InterRAI assessment was completed at any stage during Mrs A's stay.

¹ This service aims to prevent acute hospital attendances across the Auckland, Counties Manukau, and Waitematā District areas.

² Nerve pain from an injury or irritation to the sciatic nerve, felt in the lower back or legs.

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9. On admission, Mrs A's primary care did not transfer to the KVRH GP, Dr C, but remained with Mrs A's local medical centre. RN D documented this in her handover notes but did not list it under 'vital information' on Mrs A's care plan. When Mrs A became a permanent resident, there was a delay in the transfer of care to Dr C. The progress notes indicate that a transfer request was made on 17 February 2022; however, the local medical centre did not receive this until 25 February 2022, and Dr C told HDC that he did not admit Mrs A into his care until 3 March 2022.

Management of PIs

10. During her stay at KVRH, Mrs A developed a large PI on her sacrum and another on her left heel. Mrs A's family believe her skin was intact on admission to KVRH. KVRH's Skin Care and Wound Management policies (both dated 2020) provided staff with the relevant guidance.
11. On 27 January 2022, progress notes indicate that RN D identified a 'pressure area' on Mrs A's left heel after being called to replace a dressing that had been in situ since Mrs A arrived at KVRH nine days earlier. RN D documented that she started a wound management plan (WMP) but provided no other information about management. On 30 January 2022, enrolled nurse (EN) F estimated the wound to be a stage one PI³ and noted in the progress notes that the ankle dressing came off immediately when changed; however, there is no corresponding entry in the WMP.
12. Mrs A's family reported that the heel was weeping and undressed when they visited her on 8 February 2022. The WMP states that the dressing should have been changed every three days, or as required. There are no entries in the WMP between 27 January and 1 February 2022, but the record does indicate that, between 2 and 15 February 2022, the dressing was changed every one or two days. There is no entry for 8 February 2022, but the entries of 7 and 9 February 2022 both state 'dressing dry and intact'. The family told HDC that they requested that a heel protector be used but were told these were not available at KVRH. It does not appear that these concerns were documented by KVRH staff.
13. The progress notes indicate that caregivers first raised concerns about the sacral PI on 26 January 2022. Although RN E reviewed and dressed the wound, she did not recognise this was a PI or begin a WMP. Progress notes suggest that a photograph was taken of the wound; however, Dr C told HDC that a lack of training meant that RN E did not know how to upload the photograph onto the care management system. On 30 January 2022, EN F identified that the wound was a PI and estimated it to be stage two or three; she commenced a WMP, and another RN commenced two-hourly turns. A pressure-relieving air mattress was recommended but was not placed on Mrs A's bed until 2 February 2022 as staff could not find it. Mrs A's family were not informed of the sacral PI until 2 February 2022.
14. Dr C told HDC that Mrs A should have been referred to her own GP when the PIs were identified as she was still under the care of her local medical centre at this point. Nursing

³ An internationally agreed classification system for the stages of PIs is based on the depth of skin tissue damage, ranging from stage one (skin intact) to stage four (full thickness tissue loss).

staff asked him to review Mrs A on 14 February 2022, and he prescribed antibiotics for her sacral PI before she transferred into his care on 3 March.

15. KVRH referred Mrs A to a Wound Nurse Specialist (WNS) on 2 February 2022; she reviewed Mrs A via video call on 10 February 2022 and deemed the PI to be unstageable (it could not be accurately assessed). Her advice included keeping the head of Mrs A's bed at 30 degrees (except at mealtimes), the use of knee breaks (either a bend in the bed at the knees or a wedge placed under the knees) to prevent Mrs A from sliding down the bed and seeking a dietitian review.
16. The WNS initially discharged Mrs A following the remote assessment but reviewed her in person on 15 February 2022 following further concern about the management of the PI raised by Mrs A's family. The WNS noted the difficulties in the adhesion of secondary dressings because of the location of the wound and applied Mepilex, a dressing specifically designed for the sacral area. In a clinical letter detailing the appointment, the WNS recommended ensuring Mrs A was not suffering from constipation and trying Metamucil (a fibre supplement) to reduce the risk of faecal matter entering the wound. None of the recommendations from these WNS reviews were documented within the progress notes or the WMPs.
17. Mrs A's family remained concerned about the progression of the PI and advocated for her admission to hospital. Mrs A was admitted to the local public hospital on 17 February 2022, at which time the wound was surgically debrided and found to be infected by *Morganella morganii*.⁴
18. Mrs A was discharged back to KVRH on 28 February 2022 with a vacuum-assisted closure (VAC) dressing to promote wound healing. KVRH were given training and provided with two spare VAC dressings. KVRH ordered additional dressings on 2 March 2022, but they were out of stock because of supply issues relating to the COVID-19 pandemic. Mrs A's family state that regular dressings were used between 3 and 7 March 2022 when they sourced additional supplies from the hospital and brought them to KVRH. In contrast, the sacral WMP states the VAC dressing was reapplied on 2 March 2022 and that the dressings ran out on 5 March 2022, at which point regular dressings were used and the enduring power of attorney (EPOA) was made aware.⁵

Nursing intervention and care management

19. Mrs A's family were concerned about the decline in her mobility following admission to KVRH. RN D's admission note states that Mrs A was 'able to mobilise using walking frame and x1 assist.' On 21 January 2022, Mrs A told visiting family members that she was unable to walk. After this visit, the progress notes reflect repeated attempts from staff to engage Mrs A in standing; however, her ability to engage with this fluctuated, she sometimes refused or was reported to be unsteady on her feet, even when supported by two

⁴ An opportunistic bacteria often found in the intestinal tracts of humans and other mammals.

⁵ Three of Mrs A's children were closely involved with her care. Ms B was her personal care and welfare EPOA, and another daughter was her property EPOA. A third daughter was also involved with her mother's care and was noted by KVRH to be the first point of contact for Mrs A.

caregivers. KVRH's physiotherapist initially recommended the use of a standing hoist to assist with transfers, but staff found this to be unsafe and used a full sling hoist. The physiotherapist suggested that staff used their discretion for the level of transfer and noted that Mrs A was not always willing or able to engage with transfers.

20. The progress notes do not reflect consideration as to why Mrs A was not mobilising well. Dr C told HDC that this would be due in part to the PIs but also due to her increased frailty, falls, sciatica, and cognitive impairment. As the severity of Mrs A's PIs increased, she was increasingly bedbound. The progress notes show that Mrs A had frequent family visits, and they requested that she was taken out of her room for mealtimes. Despite this, the repositioning chart suggests she often ate meals in bed. There is no care plan to indicate how the risk of social isolation and the impact of being bedbound on Mrs A's wellbeing was to be managed.
21. Family members were also concerned that they found Mrs A lying flat and facing the wall in a stiflingly hot room on 8 February 2022. They report that a plan was agreed with the clinical nurse coordinator but there is no evidence of this conversation or the agreed plan to resolve these concerns.
22. Mrs A was doubly incontinent. Her care plan states that she required full assistance in accessing the toilet. Mrs A's family reported that they found her in a soaked incontinence pad on 1 February 2022 and were concerned that staff told her to void in her pad instead of supporting her to the toilet. Her repositioning and bowel movement charts (dated from 17 February) suggest that Mrs A's pad was sometimes checked during the two-hourly turns, but caregivers were not consistent in their documentation. Some recorded within the comment section that they checked the pad, and others left these sections blank.
23. There is no short-term care plan regarding Mrs A's two-hourly repositioning or the advice from the WNS. The repositioning charts indicate that Mrs A was not always turned every two hours (with no comment provided to explain why this was the case) and there is limited evidence that Mrs A was being turned regularly during the night. The food and fluid chart (also dated from 17 February 2022) shows that Mrs A's appetite fluctuated, and she would eat varying amounts at breakfast and lunch. There are very few entries after 12pm each day. Despite this information being recorded, there is no evidence of analysis of these charts from nursing staff.
24. It is also unclear from the documentation as to what extent Mrs A was supported to get out of bed to use the toilet. This was recommended by the WNS as it would reduce the risk of faecal matter contaminating Mrs A's sacral PI. In the progress notes, RN F requested that caregivers encourage the use of a commode on 13 and 16 February 2022; however, there is no further reference to the use of a commode following Mrs A's return to KVRH from the local public hospital on 28 February 2022.

Analysis

Management of PIs: KVRH – breach

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25. As a healthcare provider, KVRH is responsible for providing services in accordance with the Code. In reaching the opinion that KVRH has breached the Code, I have considered the in-house aged care advice provided by RN Jane Ferreira (see **Appendix A**).
26. RN Ferreira states that short-term admissions to rest homes are high risk and require senior nursing oversight and holistic nursing interventions. KVRH appears to have admitted Mrs A with limited information available to it and did not seek additional information from NASC, who were unaware of Mrs A's admission as a permanent resident despite involvement with her prior to her fall. RN Ferreira notes that, for someone with Mrs A's medical history, it would have been accepted practice for her to be holistically assessed within 24 hours of admission. I am critical that, although Mrs A was admitted by an RN, several assessments and her care plan were incomplete, with the latter dated several weeks after admission, indicating a failure to follow KVRH policy and ARRC guidance. I accept RN Ferreira's advice that this represents a moderate departure from the expected standard of care.
27. The KVRH Resident Admission policy indicates that any contact with relatives regarding a resident's wellbeing should be documented in the progress notes. The notes reflect some of the discussions with family, such as the request that Mrs A eat her meals out of her room and for staff to be firm with her to encourage mobilisation; however, I note that these requests were not always followed through. I am concerned that the multiple issues raised on 8 February 2022 and the agreed follow-up actions were not documented. RN Ferreira notes that a multidisciplinary meeting may have helped establish goals for Mrs A's care. I am of the opinion that including Mrs A's family in such a meeting, with input from her GP, a senior KVRH RN, the physiotherapist, and the WNS, could have aligned expectations, ensured appropriate care plans were in place, and provided Mrs A with more consistent care.
28. Mrs A's risk of developing PIs was not assessed on admission. RN Ferreira highlights that skin assessments are used to check skin integrity, identify signs of skin breakdown and support practice decisions. Therefore, had the assessment occurred, appropriate interventions could have been initiated earlier to reduce the risk of Mrs A developing PIs. I am critical that, even after the development of two PIs, no further skin risk assessment appears to have been undertaken.
29. KVHR's Skin Care and Wound Management policies provided staff with guidance on what to do when PIs were identified. This included the use of short-term care plans and escalation processes. Although assessment from a WNS was sought, I note RN Ferreira's comments that there is a lack of individualised care planning and that accepted practice would have been to review Mrs A's nutritional status and seek GP, physiotherapist, and dietitian input. I am critical that Mrs A's care was not escalated to her GP and other relevant professionals and that no short-term care plan incorporating the recommendations from the WNS was initiated.
30. Furthermore, I am concerned about the delays in identifying the PIs and providing Mrs A with an air mattress and about the lack of photographs taken to document the progression/healing of the wounds (as required by the Skin Care and Wound Management policies). This highlights a lack of communication and coordination between staff,

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reinforcing comments made by Dr C, who told HDC that at times he did ward rounds without input from nursing staff, which made handover and communication ineffective.

31. With respect to the VAC dressings, I acknowledge the supply issues arising from the COVID-19 pandemic, but I also note the family's concerns about the deterioration of the wound and consider that nursing staff could have sought further advice on managing the wound to prevent deterioration while they awaited delivery of VAC dressings.
32. Given the number of concerns highlighted, I accept RN Ferreira's advice that the management of Mrs A's Pls represents a moderate to serious departure from the standard of care.
33. I acknowledge that KVRH was impacted by illness and staffing limitations due to the COVID-19 pandemic and note that this will have placed pressures on all staff, likely disrupting usual processes and communication. However, I highlight RN Ferreria's advice that respite stays are high risk. Therefore, careful consideration should have been given to the resource limitations at KVRH before they accepted the referral for a short-term stay and subsequent permanent resident.
34. The policies and procedures in place at the time of the events were not followed consistently by KVRH staff, and the quality of documentation from caregivers varies. This highlights a lack of clinical oversight from management and senior nursing staff, who were responsible for overseeing the admissions process and developing care plans to direct the support given to residents.
35. There were a number of delays relating to the management of Mrs A's Pls, which would have impacted on her comfort, dignity, and mental wellbeing as she became bedbound in an unfamiliar environment.

Mrs A's nutritional and fluid intake: KVRH – adverse comment

36. KVRH's Skin Care and Wound Management policies highlight the importance of good nutrition and hydration for wound healing and prevention of pressure sores. RN Ferreira notes that it is unclear whether the RN team recognised Mrs A was at risk of malnutrition and dehydration given her increasing frailty, falls, and functional decline. Although a food and fluid chart was initiated, there is no evidence of analysis, and the nutrition section of Mrs A's care plan was blank. There is no indication that a dietitian review was sought, as recommended by the WNS. As such, I accept RN Ferreira's advice that this was a moderate departure from accepted standards.

Conclusion

37. For the reasons outlined above, I consider that Kumeu Village Aged Care Limited did not provide services to Mrs A with reasonable care and skill. Accordingly, I find it in breach of Right 4(1) of the Code. I also make an adverse comment in relation to the lack of consideration of Mrs A's nutritional and fluid intake.

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Distribution

38. A copy of this report with details identifying the parties removed, except Kumeu Village Aged Care Limited and my expert advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.
39. A copy of this report with details identifying the parties removed, except Kumeu Village Aged Care Limited and my expert advisor, will be sent to HealthCERT and Health New Zealand.

Rose Wall

Deputy Health and Disability Commissioner

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Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from RN Jane Ferreria:

‘CLINICAL ADVICE – AGED CARE

CONSUMER : Mrs [A]

PROVIDER : Kumeu Village Care Home

FILE NUMBER : C22HDC01591

DATE : 28 November 2023

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Kumeu Village Care Home. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner’s Guidelines for Independent Advisors.
2. **Documents reviewed.**
 - Letter of complaint received 29 June 2022
 - Forrest Hill Home and Hospital response received 5 August 2022
 - Kumeu Village response received 23 August 2022
 - Clinical records, including nursing assessments, care plans, monitoring forms, wound care plans, medical notes, and health records, including hospital information.
 - Organisational policies, including adverse event, nutrition, care plan, skin care and pressure area injuries, wound management, and complaints management.
3. **Complaint**
[Mrs A]’s family have expressed concern regarding the clinical care provided to their mother while she was resident at the care home between 18 January and 16 March 2022. Their concerns relate to a lack of clinical oversight, nursing assessment, continence management, pressure injury prevention and management, nutritional management, wound care, and poor communication.
4. **Review of clinical records**
For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

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- Nursing assessment, pressure injury prevention and management, nutritional needs, clinical leadership, care oversight, and communication
- Improvements made by the provider in response to this complaint.

Background

[Mrs A] was admitted to the care home from hospital on 18 January 2022 as a short-stay resident following a fall event. Prior to admission, she lived at home supported by her whānau/family and community care teams. Her medical history included an aortic aneurysm, chronic obstructive pulmonary disease, sciatica, cognitive impairment, and chronic bowel and bladder incontinence. Preadmission information indicated that [Mrs A] had experienced frequent falls related to functional decline. She mobilised with a walking frame and supervision and required a high level of assistance to meet her care and safety needs. [Mrs A]'s level of mobility declined during her admission, and she developed sacral and heel pressure injuries that required hospitalisation for further care. [Mrs A] transferred to another service provider on 18 March 2022. She continued to experience health decline and passed away [in] April 2022. I extend my condolences to [Mrs A]'s family at this time.

a) Please comment on the admission process, nursing documentation and the use of risk assessments.

The organisation's Care Plan policy (2020) states that the admission assessment will utilise information gathered from the resident, their nominated representatives, the referring agency, or previous health provider, with relevant observations and assessments completed. The Care Plan policy provides timeframes for nursing assessment and care plan development, which appear to be in line with sector contractual requirements.

The electronic file record reflects that [Mrs A] was transferred via ambulance from hospital (emergency department) to the care home on 18 January 2022 for two weeks of respite care following a fall event at home. The admission nursing entry completed by an RN refers to receiving a verbal nursing handover from the discharging team's RN. The entry provides a health outline with discussion of [Mrs A]'s care and safety requirements, noting signs of bruising with wound dressings to her eyebrow and upper and lower limbs. Vital signs were recorded, and a range of nursing assessments were completed that included cognitive function, continence and toileting, hygiene, mobility, transfers, falls and safety. It appears that skin integrity, pain, nutritional status, and wound or pressure injury risk assessments were not completed as part of admission and wound care management responsibilities at this time. Given [Mrs A]'s medical history, recent fall event with injury, and chronic continence concerns, it would be considered accepted practice to ensure that she was holistically assessed by an RN within 24 hours of admission to identify acute clinical issues or safety concerns to inform her respite plan of support.

There appear to be communication and documentation anomalies within the admission process, with file information indicating that the Needs Assessment Service Coordination (NASC) team were not aware of [Mrs A] short-stay placement at the care home, which was funded under Primary Options for Acute Care. Nursing notes indicate that preadmission nursing and medical information was not available to the admitting team, which raises

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concern regarding the provider's admission process. As outlined in the Age-Related Residential Care (ARRC) services agreement (2022), a needs assessment is required to inform care and service delivery requirements. While the Resident Admission policy was not included in the submitted evidence, accepted nursing practice would be to ensure that all essential nursing and medical information was obtained prior to the new resident's arrival to ensure appropriate continuity of care, in partnership with the funder's requirements.

It is unclear whether the clinical leaders had an opportunity to communicate with [Mrs A]'s nominated representative and whānau/family prior to or during the admission process to establish her goals for care. While data collection is essential during the admission process, it is also important to consider the discharge process and transfer of care responsibilities at the end of the respite period.

Short-stay resident admissions can be high risk and require collaborative care coordination to ensure care and safety needs are consistently met. It is unclear what senior nurse oversight of the admission process was provided by the clinical manager or how [Mrs A]'s assessed needs as a new admission were communicated to the incoming shifts to ensure safe coordination and delivery of her care. As a comment, there appears to be limited care planning guidance available, with no evidence of nursing reassessment provided or GP assessment sought when [Mrs A] was identified with mobility and health changes. I note that the provider response, GP response, and investigation report have discussed the impact of COVID-19 and workforce challenges at the time, which may have contributed to missed care events, with identified areas for improvement.

From the evidence reviewed to respond to this question, it appears that the admission process for [Mrs A]'s respite stay was below the accepted standard in the circumstances. While reviewed policies indicate that systems and processes were in place, it appears there were gaps in clinical leadership and delays in recognising and prioritising [Mrs A]'s specific care requirements by the nursing team during her stay at the care home. I consider these to be moderate departures from accepted practice, and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

b) Please comment on the nursing interventions provided to [Mrs A] on identification of the sacral and heel pressure injuries. Were these actioned in a timely manner and were interventions in line with expected nursing practice?

The Skin Care and Wound Management policies (2020) outline nursing responsibilities when pressure injuries are identified. The policies discuss the use of short-term care plans, pain, mobility, nutritional and wound assessments, escalation processes, including referral and reporting requirements.

There appear to be delays in completing wound assessments and management plans for [Mrs A]. Records show that concerns with [Mrs A] skin integrity were first reported to an RN on 26 February 2022, eight days post-admission. Progress notes from 27 January state that [Mrs A] had had a dressing on her left heel since admission. As identified by the provider, it

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is unclear whether [Mrs A]’s skin integrity was intact on admission to the care home or if she was admitted with an existing PI.

As outlined in the Health Quality & Safety Commission Te Tāhū Hauora (HQSC) Frailty Care Guides, skin assessments are used to check skin integrity and identify signs of risk, concern, or areas of breakdown, particularly across bony prominences such as the heels or sacrum. It is also an opportunity to assess a resident’s skin colour, nutrition and hydration status while checking for signs of bruising, lesions, wounds, or pressure injuries. Assessment findings are used to inform incident management and external reporting requirements and support evidence-based practice decisions (HQSC, 2019; HQSC, 2023).

File information indicates that, once the sacral injury was identified, a wound management plan was commenced and a referral was sent to a wound nurse specialist (WNS) for care guidance. Similar steps were evidenced for the heel injury on 27 January 2022; however, it is unclear whether incident forms were completed for these sites or whether Section 31 external reporting occurred for the unstageable sacral injury in line with the organisation’s Adverse Event policy. There is no record of escalation to [Mrs A]’s GP for medical assessment or guidance sought, which would be considered accepted practice. Health records show that medical processes were blurred during the respite period, with [Mrs A] remaining under the care of her primary GP until transferring to the care home GP as a permanent resident. It appears there were delays in accessing health records and care information, resulting in [Mrs A] being medically admitted on 3 March 2022. Medical notes evidence GP input, with further visits on 11 and 14 March 2022 regarding [Mrs A]’s declining sacral pressure injury and treatment plan prior to her discharge on 16 March 2022.

Delivery of wound care is reflected in the electronic wound management plan and progress notes; however, there appears to be limited evidence of senior nurse review of [Mrs A]’s holistic needs at this time. Wound records indicate inconsistencies with assessment and wound dressing timeframes and the use of wound products; however, I acknowledge that this may be due to pandemic-related product supply issues at this time. There appears to be minimal evidence of pain assessments, recording of vital signs or weight changes, or monitoring of oral intake, elimination requirements, or commencement of an individualised plan of care. Accepted practice would be to review [Mrs A]’s nutritional status, request a GP and physiotherapy assessment, and consider dietitian input regarding the use of dietary supplements to support wound healing. It appears that food and fluid monitoring and repositioning forms were only commenced on 17 February 2022, with no apparent evidence of RN evaluation. Entries in the care record refer to the use of specialist pressure-relieving equipment, an air mattress and roho cushion, and regular repositioning; however, there is no evidence of health professional guidance to support [Mrs A]’s chronic obstructive pulmonary disease care requirements. It does not appear that her social needs were considered, with a risk of boredom and loneliness while on bedrest.

[Mrs A]’s whānau/family have expressed concern regarding continence management, toileting, and appropriate use of products. Progress notes from 5 February 2022 refer to [Mrs A] experiencing mobility difficulties impacting effective toileting. Entries refer to the use of a standing hoist to transfer from bed to chair, but it is unclear if she was offered a

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mobile commode chair to transfer to the toilet, in line with WNS guidance to support effective elimination, continence management, and skin integrity.

From the evidence reviewed to respond to this question, it appears that, once the pressure injuries were identified, the care team responded in a timely manner; however, there are opportunities for improvement in nursing assessment, care planning, communication and escalation, timely clinical care, and documentation standards, which would be viewed similarly by my peers. As outlined in question (a), short-stay admissions can present a high risk and require close clinical oversight to ensure that all resident needs are safely met. As outlined by the HQSC, pressure injuries are considered a harm event and have a significant impact on wellness and quality of life (HQSC, 2019; HQSC, 2023). I note that the provider has completed additional education on this topic as part of their investigation's corrective actions. I also recommend they review their Resident Admission policy, Skincare and Pressure Injury Prevention and Management policies, and Incident Management and Adverse Event policies to ensure that all team members are aware of their responsibilities to resident safety.

- Departure from accepted practice: Moderate to serious.

c) Do you consider the nutritional oversight of [Mrs A]'s care met an acceptable level of nursing practice with regard to management of a severe pressure injury.

As outlined in questions (a) and (b), there are identified deviations from accepted practice regarding the management of [Mrs A]'s nutritional needs. There is no evidence that a risk screening assessment was completed on admission or repeated following identification of a pressure injury. Page 18 of the care plan report is incomplete with no relevant information provided about nutritional requirements.

Reviewed records indicate that [Mrs A]'s appetite was fluctuating; however, it does not appear that she was commenced on weekly weighs at this time, which would be considered accepted practice. Monitoring of oral intake was only commenced on 17 February 2022, and there is limited evidence of RN analysis, identification of concern, or escalation to the GP. It is unclear if the RN team recognised that [Mrs A] was at risk of malnutrition and dehydration given her preadmission history of functional decline, a recent fall event, changes in healthcare environments, eye and sacral surgeries, and history of cognitive impairment with increasing frailty.

Progress notes reflect whānau/family support and involvement at mealtimes; however, it is unclear if the clinical leaders recognised a need for a GP assessment and multidisciplinary meeting to establish goals and a plan for care. I note the provider response regarding available workforce and competing priorities at the time, which may have contributed to the standard of care delivery in the circumstances.

From the evidence reviewed to respond to this question, it appears that the level of nutritional oversight provided to [Mrs A] following identification of her pressure injuries was below the minimum standard of accepted practice in the circumstances. It appears that guidance provided in the submitted organisational policies was not followed. This would be viewed by my peers as a moderate deviation from accepted practice.

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- Departure from accepted practice: Moderate

d) Do you consider the facility response and corrective actions adequately address deficits identified to ensure prevention of further similar outcomes?

The provider has acknowledged and apologised in their response for findings based on their investigation. They have discussed their commitment to improvement and submitted evidence of training sessions delivered as part of corrective actions identified in response to this complaint. This has included agendas, attendance records, clinical topics, and supporting training material regarding continence management, skincare, wound care and care of pressure injuries, nutritional and dietary assessments, nursing assessment, care planning, and care evaluation.

In addition to these sessions, I recommend that the team consider a review of the resident preadmission and admission process, including the roles and involvement of other stakeholders in resident care, and how essential clinical information is communicated across the care team, particularly for short-stay resident admission.

I recommend further training about signs of acute and gradual resident deterioration and a review of nursing responsibilities across the resident journey from admission to departure as a learning opportunity.

5. Clinical advice

I note that the events occurred during the COVID-19 pandemic period 2020–2022 and would like to acknowledge the challenges and distress caused to residents, whānau/family, care teams and health service providers during this time.

Nursing risk assessments are clinical tools that need to be supported by clinical judgement. It is important to utilise a holistic assessment lens and implement both preventive and supportive measures according to the identified risk. As outlined in the [Frailty Care Guides](#), [New Zealand Wound Society resources](#) and organisational policy, it is important to consider personalised goals for care, with an aim to promote healing, safety, and comfort and to prevent decline.

Based on this review, I recommend the care home team complete additional education on communication with and about older people and their whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend discussion with the RN team regarding the importance of accurately recording all concerns raised by the family in the resident's clinical record and implementing the use of the ISBAR communication tool to better inform clinical assessments and actions and safe, evidence-based decision-making. To support this approach, I recommend that the care home team complete the HDC online modules for further learning: <https://www.hdc.org.nz/education/online-learning/>

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Jane Ferreira, RN, PGDipHC, MHLth

Nurse Advisor (Aged Care)

Health and Disability Commissioner

References

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New Zealand Wound Society. Pressure Injury Resources.

<https://www.nzwcs.org.nz/resources/pressure-injury-public-resources>

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