Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 20HDC00374)

Introduction

1. On 24 February 2020 this Office received a complaint from Ms A about the care provided to her late father, Mr B, when he developed a pressure injury at Mayfair Lifecare (2008) Limited (Mayfair) in 2019.

2. The following issue was identified for investigation:

   - *Whether Mayfair Lifecare (2008) Limited provided Mr B with an appropriate standard of care during Month1 to Month3 (inclusive).*

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

Background

4. Mr B (aged in his eighties at the time) had been a resident of Mayfair in hospital-level care from 2012 after suffering a major stroke three months prior to his admission.

5. The stroke affected Mr B's mobility and his ability to communicate. Mr B had care plans in place to manage his stroke symptoms, such as being assisted with his meals, assisted with

Names have been removed (except Mayfair Lifecare (2008) Limited and HDC's advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

repositioning, having regular physiotherapy, and participating in activities adapted for his safety.

6. Ms A had an activated enduring power of attorney (EPOA) for Mr B's welfare at the time of these events.

Timeline of events

Overall health decline Month1–Month3

7. In Month1 there was an outbreak of a viral gastrointestinal illness at Mayfair and the residents were put into isolation. Mr B's cognition and general condition appeared to decline after this event.

8. On 24 Month1 it was discovered that Mr B had a wound on his sacrum, which was deemed as moisture associated. A wound chart was commenced to monitor details about the wound (size, location, etc) and to provide a treatment plan (wound dressing to be used, frequency of dressing changes). The management of Mr B's wound is discussed further below.

9. Mr B's overall health condition continued to decline in Month2. Progress notes on 7 Month2 record that Mr B was 'very vacant and sleepy' and was not actively moving around in his bed.

10. On 12 Month2 general practitioner (GP) Dr C noted that Mr B was not moving his arms or legs and was unable to talk. It appeared to Dr C that Mr B may have had another stroke.

11. Mr B's overall health continued to decline in Month3. On 21 Month3 it was noted that Mr B was very settled but had a glazed expression and reduced awareness.

12. Progress notes on 27 Month3 record that a GP[1] reviewed Mr B because he had deteriorated overnight. After a discussion with Ms A, who was with her father, Mr B was commenced on comfort cares.[2] Sadly, Mr B passed away later that day.

Wound care

Wound management policy

13. At the time of events, Mayfair had a wound management policy (April 2019), the purpose of which was to 'optimise healing for residents with a wound by providing co-ordinated, appropriate and clinically correct care and treatment based on current best practice'. The policy provided the following requirements:

- A wound chart is to be completed for each wound, which is the primary document for wound care, that includes information such as the location, treatment objectives, and interventions to promote healing of the wound such as specific wound dressings.

[1] Covered GP care when Dr C was away on leave.

[2] A patient care plan that is focused on symptom control, pain relief, and quality of life.

- Information about the wound, such as the appearance of the surrounding skin, the size of the wound, the dressing used, the exudate[3] from the wound, needs to be documented each time the dressing is changed and wound assessed.
- When changing the wound dressing, the resident's pain levels must be considered every time, and it would be prudent to ensure the resident has had appropriate analgesia prior to renewing the dressing.
- The registered nurse is to report to the clinical nurse manager or wound care specialists as necessary and all stage 3/4 and unstageable pressure injuries are to be reported to HealthCERT.'

14. Several wound charts were in place for Mr B that referred to the same wound. The first wound chart was commenced on 24 Month1 and titled 'Moisture Associated Skin Damage (MASD)'. This chart was discontinued on 7 Month3 as the wound had developed into a pressure injury. Two further wound charts were commenced on 29 Month2 and titled 'Pressure injury stage 2'. These charts were discontinued on 13 Month3 following clinical nurse specialist direction. The fourth wound chart was commenced on 30 Month2.

15. Ms A told HDC: 'I was notified that dad had a pressure sore. The severity of it seemed to change with whichever staff member was on.'

16. On 29 Month2 it was noted that the wound had developed into a stage 2[4] pressure injury with necrotic[5] tissue evident.

17. On 5 Month3 it was noted that Mr B's pressure injury showed further breakdown. A wound swab was taken and a referral to the district nurse was made for wound care input.

18. On 10 Month3 Dr C was asked to review Mr B's pressure injury. Dr C was accompanied by the district nurse. Because the pressure injury was large, Dr C made an urgent referral[6] for a clinical nurse specialist[7] review and discussed Mr B's treatment with a plastic surgery registrar. Following the results of the wound swab, Mr B was prescribed an antibiotic to treat infection.

19. Progress notes on 11 Month3 document Dr C's interaction with the plastic surgery registrar. The registrar indicated that surgery was not appropriate as it was possible that Mr B would not cope well. The registrar suggested chemical debridement,[8] and to continue using the air-alternating mattress, regular repositioning, and appropriate wound dressings.

[3] Fluid that seeps out of wounds.
[4] The severity of a pressure injury is graded 1 to 4, to specify the level of tissue damage the person has experienced. A stage 2 pressure injury affects the deeper layers of the skin and forms an ulcer. It is tender and painful.
[5] Dead.
[6] To an organisation that provides community and acute nursing care in the region.
[7] A nurse who specialises in a particular area of care, such as wound care.
[8] The use of an ointment or gel to soften unhealthy tissue so that it can be removed safely.

20. On 13 Month3 the clinical nurse specialist[9] assessed Mr B's pressure injury and commenced a wound chart that noted the size and condition of the wound tissue, what wound dressings to use, and how often to change the dressings. She noted that Mr B was getting '[p]ain from [the] pressure injury — especially at dressing change'. She also noted that the pressure injury was now 'ungradable[10]'.

21. Progress notes on 19 Month3 record that the clinical nurse specialist reviewed Mr B's pressure injury again and redressed it. She told staff to continue the wound care plan daily until further instruction.

22. HealthCERT was informed of Mr B's unstageable pressure injury on 27 Month3.

Pain management during dressing changes

Medication management policy

23. At the time of events, Mayfair had a medication management policy (April 2019), the purpose of which was to 'ensure that all residents receive medications in a safe and timely manner'. The policy provided the following:

- When PRN[11] medication is prescribed on Medi-Map[12] the GP must document the reason why the medication was prescribed and include instructions, frequency, and rationale for use. This entry is to be written in a way that it can be clearly read without risk of misinterpretation.
- The comments box on Medi-Map should 'always be used for PRN medications to record the reason for the administration and the [dose] given'.
- When a PRN medication is administered, the reason for giving the medication and whether it was effective must be written in the resident's progress notes.

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

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

25. Progress notes written by a palliative care specialist on 22 Month2 record that Ms A's main concern was the occasional pain episodes experienced by Mr B, and that when she asked for pain relief, at times it was not given. The palliative care specialist reinforced to staff to try PRN morphine and to assess its effect on Mr B's pain.

[9] Employed by the community and acute nursing care organisation.
[10] The wound contains too much dead tissue to see the extent of the injury. This is the most severe type of pressure injury.
[11] As required.
[12] Medi-Map is an electronic medication management system that enables GPs, pharmacists, and aged care nurses to share residents' medication charts. It allows medication charts to be updated in real time and is accessible from any device with internet access.

26. On 25 Month2 Mr B was prescribed PRN oral morphine for pain, with instructions on Medi-Map to 'give [to Mr B] at least 30 minutes prior to dressing change'. Dr C's rationale for prescribing morphine at least 30 minutes before Mr B's pressure area dressings was to account for his difficulty communicating and to ensure that the morphine had taken effect before Mr B's dressing changes were done.

27. Progress notes on 17 Month3 document that Dr C reinforced these instructions to staff to ensure that Mr B would not be in pain while the dressings were changed, because he could not verbalise his pain due to his stroke.

28. A table summarising when Mr B was given pain relief prior to his dressing changes is included as Appendix A. The table includes information about whether pain relief was given and its effectiveness.

29. As reflected in the table, from 26 Month2 until 26 Month3, 30 entries in Mr B's progress notes refer to dressing changes. The following is noted:

- Out of the 30 entries, it is documented only six times that Mr B was given morphine prior to his dressing change.
- Out of these six times, the effect of the morphine on Mr B's pain was noted only four times, and only two entries gave more detail on the dose, route, and reason for giving the medication.

Pressure injury care and repositioning of Mr B

Pressure injury prevention and management policy

30. At the time of events, Mayfair had a pressure injury prevention and management policy (April 2019), the purpose of which was to 'ensure optimum skin integrity, comfort, dignity and quality of life is promoted' for every resident in its care.

31. The policy notes that residents most at risk of pressure injuries are those who have lost some degree of physical function.

32. The policy provides that regular turning/repositioning of the resident, usually every two hours, is necessary and should be recorded on the pressure care chart every time it is done.

33. The policy indicates that pain relief is provided to 'ensure the resident is made as comfortable as possible' in line with the pain management policy.

34. It was noted on Mr B's care plan that his pressure injury risk score was 22, which indicated a very high risk, and so initially he was nursed on a pressure-reducing mattress,[13] and later, as his pressure injury developed, on an air-alternating mattress.[14]

[13] A mattress that redistributes a patient's weight to relieve pressure points.
[14] A mattress that contains air cells that are continually inflated and deflated to relieve pressure points and promote better circulation.

35. A pressure care chart was commenced on 24 Month1 when Mr B's pressure wound was first documented. When a resident is repositioned, this is to be recorded on the pressure care chart. Mr B was to be repositioned regularly to prevent any further pressure injuries and to allow his sacral wound to heal.

36. A table summarising when Mr B was repositioned is included as Appendix B. The table includes information about how often he was repositioned and whether this information was recorded on his pressure care chart and/or in his progress notes.

37. As reflected in the table, from 25 Month1 to 27 Month3, the following was noted:

- The progress notes started recording repositioning from 9 Month2.
- On 21 dates, Mr B's repositioning was not recorded on the pressure care chart.

Further information

Mayfair

38. Mayfair accepted that pain relief was not administered on a regular basis prior to Mr B's dressings, and that Ms A's concerns about his pain were not always considered by staff. Mayfair acknowledged that there were several wound charts and it was not clear which was being followed, and that there were missing entries on one chart. Mayfair also accepted that the documentation of Mr B's repositioning was not completed consistently.

39. Mayfair told HDC:

> '[Mayfair is] sincerely apologetic for any additional distress caused for [Ms A] and her father in the months leading up to his passing. [We have] continued to review [our] processes to ensure the learnings from this complaint are reflected in the standard of care delivered.'

Responses to provisional opinion

40. Mayfair was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. It acknowledged that having more than one wound chart open affected co-ordination of wound management. Mayfair accepted that it did not always document when Mr B was repositioned, and that its expectation was that this documentation was to occur.

41. Mayfair also submitted that in its view, prescribing Mr B's pain relief as PRN or 'as required' medication may have been interpreted differently by different nursing staff and added that a prescription such as 'QID[15] 30 minutes before wound dressings to manage procedural pain' would have been preferred. I disagree with Mayfair's submission that Mr B's prescription was unclear and that by substituting the term 'PRN' with 'QID' would have resulted in less confusion by the staff. These drug administration terms are vastly different. If Mr B's pain relief was prescribed 'QID' as submitted by Mayfair, Mr B could

[15] QID means 'four times a day' in relation to drug administration.

have received unnecessary pain relief four times on a day when the wound dressing may not be scheduled to be changed.

42. Mayfair subsequently submitted to HDC:

> '[t]he key point we raised is that PRN prescribing is open to a wide range of judgement and interpretation. If wound dressings are known to be painful it is perhaps more appropriate to prescribe the related analgesia as regular medication (in relation to the number of times a day the dressing is being attended to).'

43. In my opinion, Dr C's pain relief prescription 'PRN at least 30 minutes prior to dressing change' is clear and appropriate as the pain relief prescribed for Mr B was to assist with managing his pain related to his wound dressings.

44. Mayfair accepted the proposed recommendations in relation to Mr B's care and extended its sympathy to Mr B's family and 'acknowledge[d] opportunities to reflect on and continue to develop [its] practice'.

45. Ms A was given the opportunity to respond to the 'information gathered' section of the provisional opinion. She asserted that Mr B was in pain for a long time and was unable to communicate this. She stated: 'Think about how you would feel knowing your parent was in agony and you were unable to fight the system.' She said that she could not fathom how the care provided to her father could not be seen 'as anything other than elder abuse'.

Opinion: Mayfair Lifecare (2008) Limited — breach

46. I acknowledge the distress that this event has caused Mr B's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Mayfair was appropriate, I considered independent nursing advice from RN Rachel Parmee (Appendix C).

Wound care

47. On 24 Month1 Mr B developed a sacral wound. On 29 Month2 it was described as a stage 2 pressure injury. A wound swab was taken on 5 Month3, and antibiotics were prescribed. A referral to the district nurse for wound care advice was made, and by 10 Month3 the pressure injury was classed as unstageable. On 10 Month3 Dr C made referrals to a wound care specialist and to the plastics registrar for advice on management. Mr B's wound continued to be managed as per the wound care specialist's advice.

48. The wound management policy required that a wound chart be completed for each wound, and that the chart record information such as the location, treatment objectives, and interventions to promote healing of the wound, and that information about the wound be documented each time a dressing was changed.

49. The wound management policy indicated that wound care specialists should be contacted to provide wound care advice, and that any stage 3/4 and unstageable pressure injuries should be reported to HealthCERT.

50. RN Parmee noted that a wound chart was commenced on 24 Month1, two more were commenced on 29 Month2, and another was commenced on 30 Month2. The four wound charts appeared to be for the same sacral wound, and it was unclear which chart was being followed. RN Parmee also noted that on two days there was no documentation that the wound had been re-dressed.

51. RN Parmee considered that there was a moderate departure in terms of 'consistency and accuracy' of the wound care documentation. However, she advised that 'appropriate and timely' referrals were made to the district nurse and the wound care specialist, and appropriate notification was given to HealthCERT regarding the unstageable pressure injury.

52. I accept RN Parmee's advice and commend Mayfair for its appropriate and timely referrals and notification to HealthCERT. However, I am critical that four wound charts for the same wound would have been confusing and would have affected the co-ordination of Mr B's wound care.

Pain management during dressing changes

53. On 25 Month2 Mr B was prescribed oral liquid morphine, with instructions on Medi-Map to give the medication at least 30 minutes prior to his dressing changes to ensure that it had taken effect. Dr C's instructions were written clearly.

54. Over the 30-day period following the prescription of oral morphine on 25 Month2 and up until 26 Month3, 30 entries recorded that Mr B's dressings had been changed. However, on only six occasions was it documented that Mr B was given morphine prior to the dressing change.

55. Further, it was documented that his daughter, Ms A, expressed concerns that when she asked for pain relief for her father, at times it was not given.

56. RN Parmee advised that it was a severe departure from accepted practice that the pre-dressing pain relief prescribed by Dr C was not administered on a regular basis prior to Mr B's dressing changes. RN Parmee said that this 'resulted in a painful intervention being carried out without ensuring the comfort of a vulnerable resident who is immobile and unable to verbally express pain'.

57. RN Parmee also noted that Ms A's concerns about her father's pain were not considered by staff and said that this further reinforces 'the severity of this departure in that the concerns of Mr B's advocate were not acknowledged'.

58. I accept RN Parmee's advice and note that out of 30 dressing changes between 25 Month2 and 26 Month3, the records show that Mr B was given morphine only six times. I am critical that a vulnerable resident who could not verbalise when he was in pain was not

given his morphine as prescribed, and therefore likely had to endure painful dressing changes. I am also critical that when Mr B's daughter expressed concerns about her father's pain and asked for him to be given pain relief, at times this was not given. In addition, I am critical that staff did not adhere to the medication management policy when recording when morphine was given, including the rationale for its administration and its effect.

59. In my view, this raises concerns about staff adherence to policies and medication instructions, and communication with residents' advocates.

Pressure injury care and repositioning Mr B

60. Mr B was assessed as being at high risk for pressure injuries, and this was documented in his care plan. In Month2 Mr B suffered another stroke, which further affected his mobility, and he developed a pressure injury on his sacrum. This required Mr B to be repositioned regularly to prevent any further pressure injuries and to allow the pressure injury on his sacrum to heal. Initially Mr B was nursed on a pressure-reducing mattress, and later he was placed on an air-alternating mattress.

61. On 24 Month1 a pressure care chart was commenced when Mr B's pressure wound was first documented. As per Mayfair's pressure injury policy, whenever Mr B was repositioned, this should have been recorded on the pressure care chart.

62. Between 24 Month1 and 27 Month3, Mr B's repositioning was not recorded on the pressure care chart on 21 dates.

63. RN Parmee considered that the documentation of Mr B's repositioning was a mild departure from the standard of care, as it was not documented consistently on the pressure care chart. This is concerning, as adequate documentation is fundamental in managing a resident's health needs successfully.

64. RN Parmee found no departure from the standard of care in relation to pressure area prevention, as it appears that Mr B was repositioned regularly and nursed on appropriate mattresses.

65. I accept RN Parmee's advice.

Conclusion

66. In summary, I find that Mayfair did not provide an appropriate standard of care to Mr B between 24 Month1 and 27 Month3, for the following reasons:

a) Several wound charts were in place for Mr B, which made it unclear which chart staff were following, and this affected the coordination of his wound care.

b) Mr B was not given his prescribed pain relief regularly prior to his wound dressing changes, despite the clear instructions in Medi-Map for this to occur. It was especially important for the pain relief to be given as planned, as Mr B could not verbalise his pain.

c) Staff frequently did not record on Mr B's pressure care chart the times when he was repositioned.

67. Accordingly, I consider that Mayfair breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[16]

Recommendations

68. I recommend that Mayfair Lifecare (2008) Limited:

a) Provide a written apology to Mr B's family for the issues identified in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

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

i. Pain management policy

ii. Wound management policy

iii. Pressure injury prevention and management policy

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

Follow-up actions

69. A copy of this report with details identifying the parties removed, except the advisor on this case and Mayfair Lifecare (2008) Limited, will be sent to HealthCERT and Te Whatu Ora|Health New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[16] Right 4(1) stipulates that '[e]very consumer has the right to have services provided with reasonable care and skill'.

Appendix A: Timeline of Mr B's pressure area dressings and pain relief

Date of dressing change	Pain relief given?	Effect on pain?
On 25 Month2 Mr B was prescribed PRN oral morphine for pain, with instructions to 'give at least 30 minutes prior to dressing change'		
6 Month2 at 11.06am	*Not noted in progress notes*	*Not noted*
27 Month2 at 11.14am	*Not noted in progress notes*	*Not noted*
29 Month2 at 2.56pm	*Not noted in progress notes*	*Not noted*
30 Month2 at 10.13pm	*Not noted in progress notes*	*Not noted*
1 Month3 at 10.25am	*Not noted in progress notes*	*Not noted*
3 Month3 at 11.59pm	*Not noted in progress notes*	*Not noted*
4 Month3 at 2.54pm	*Not noted in progress notes*	*Not noted*
5 Month3 at 9.10pm	*Not noted in progress notes*	*Not noted*
7 Month3 at 12.22am	*Not noted in progress notes*	*Not noted*
7 Month3 at 10.18pm	*Not noted in progress notes*	*Not noted*
8 Month3 at 10.42pm	*Not noted in progress notes*	*Not noted*
9 Month3 at 11.10pm	*Not noted in progress notes*	*Not noted*
10 Month3 at 2.57pm	*Not noted in progress notes*	*Not noted*
12 Month3 at 11.18pm	*Not noted in progress notes*	*Not noted*
13 Month3 at 11.29pm	Mr B was given PRN morphine prior to dressing change. No further details recorded in progress notes	*Not noted*
14 Month3 at 11.08am	Mr B was given PRN analgesia prior to dressing change. No further details recorded in progress notes	Good effect on pain
14 Month3 at 11.02pm	*Not noted in progress notes*	*Not noted*
15 Month3 at 10.18pm	Mr B was given PRN morphine prior to dressing change as he was 'grimacing' and 'appeared uncomfortable'. Recorded in progress notes Mr B was given 2.5ml oral liquid morphine	*Not noted in progress notes* 'very settled' after morphine, recorded in

	prior to dressing change, recorded in Medi-Map	Medi-Map
16 Month3 at 10.17pm	*Not noted in progress notes*	*Not noted*
18 Month3 at 12.11am	*Not noted in progress notes*	*Not noted*
18 Month3 at 11.30pm	*Not noted in progress notes*	*Not noted*
19 Month3 at 7.40pm	PRN morphine was given prior to wound dressing. No further details. Recorded in progress notes	Minimal effect on pain
20 Month3 at 3.06pm	*Not noted in progress notes*	*Not noted*
20 Month3 at 10.40pm	*Not noted in progress notes*	*Not noted*
21 Month3 at 11.54am	Mr B was given PRN analgesia prior to wound dressing. No further details recorded in progress notes	Good effect on pain
22 Month3 at 2.16pm	*Not noted in progress notes*	*Not noted*
23 Month3 at 4.36pm	Mr B was given PRN morphine prior to wound dressing. No further details recorded in progress notes Given 2.5mg subcutaneous morphine prior to dressing change, recorded in Medi-Map	*Not noted*
24 Month3 at 7.18pm	*Not noted in progress notes*	*Not noted*
25 Month3 at 1.53pm	*Not noted in progress notes*	*Not noted*
26 Month3 at 11.50am	*Not noted in progress notes*	*Not noted*

Appendix B: Timeline of Mr B's repositioning and where documented

Date and time of reposition documented on pressure care chart	Date of reposition documented in progress notes (and time of notes entry)
Pressure care chart started on 24 Month1 when pressure area first documented	
25 Month1 at 4.00am and 8.00pm	
26 Month1 at 12.00am, 2.00am, 6.00am, 10.00pm	
27 Month1 at 5.00am	
30 Month1 at 4.00am	
31 Month1 at 3.00am and 6.00am	
4 Month2 at 3.00am	
5 Month2 at 4.00am and 8.00am	
7 Month2 at 3.00am	9 Month2 at 12.54pm and 2.49pm
10 Month2 at 3.00am	10 Month2 at 6.02am and 2.49pm
11 Month2 at 4.00am and 7.30pm	11 Month2 at 5.51am
12 Month2 at 8.30pm	12 Month2 at 6.15am and 10.58am
13 Month2 at 3.00am	13 Month2 at 5.25am
14 Month2 at 3.00am and 9.00pm	
15 Month2 at 10.00pm	15 Month2 at 5.36am
16 Month2 at 9.00pm	
17 Month2 at 10.00pm	17 Month2 at 5.26am
18 Month2 at 3.00am and 7.00pm	18 Month2 at 5.41am
	20 Month2 at 5.38am
21 Month2 at 1.00am, 2.00am and 10.00pm	21 Month2 at 5.31am
22 Month2 at 7.30pm	22 Month2 at 5.23am
	24 Month2 at 6.02am

25 Month2 at 3.00am	25 Month2 at 5.47am
	26 Month2 at 5.17am and 11.00pm
27 Month2 at 4.00am	
28 Month2 at 4.00am and 9.00pm	28 Month2 at 5.00am
29 Month2 at 8.30am, 1.00pm and 10.30pm	29 Month2 at 2.56pm
30 Month2 at 9.00am, 1.00pm and 9.50pm	30 Month2 at 5.24am and 10.13pm
1 Month3 at 6.30am and 9.00pm	1 Month3 at 5.55am and 10.38pm
2 Month3 at 3.00am	2 Month3 at 5.20am and 10.23pm
3 Month3 at 3.00am	3 Month3 at 5.29am
	4 Month3 at 5.10am
5 Month3 at 4.00am and 6.00am	5 Month3 at 5.48am and 9.10pm
6 Month3 at 12.00am, 2.00am and 6.00am	
7 Month3 at 9.00am and 1.15pm	7 Month3 at 12.22am and 10.18pm
	8 Month3 at 5.59am
9 Month3 at 4.00am and 10.00pm	9 Month3 at 11.10pm
10 Month3 at 10.00pm	10 Month3 at 5.50am
11 Month3 at 4.00am	11 Month3 at 11.50pm
12 Month3 at 4.00am, 4.00pm, 6.00pm, 8.40pm and 10.00pm	12 Month3 at 2.56pm and 11.18pm
13 Month3 at 4.00am, 6.00am, 3.30pm, 4.30pm, 5.30pm, 8.00pm and 10.00pm	13 Month3 at 5.26am and 2.44pm
14 Month3 at 4.00am, 5.30pm, 7.50pm and 9.00pm	14 Month3 at 11.08am
15 Month3 at 4.00am, 6.00am, 5.30pm, 8.00pm and 10.00pm	15 Month3 at 5.48am and 3.01pm
16 Month3 at 4.00am, 5.30pm, 7.30pm and 9.30pm	16 Month3 at 5.34am, 2.34pm and 10.17pm
	17 Month3 at 5.02am

	18 Month3 at 05.51
19 Month3 at 6.00am, 5.30pm, 7.00pm and 9.00pm	19 Month3 at 5.29am and 10.56pm
20 Month3 at 1.30am, 3.40am, 5.45am and 10.00pm	20 Month3 at 5.20am and 10.40pm
21 Month3 at 1.25am, 3.33am, 5.45am and 8.30pm	21 Month3 at 5.48am, 3.22pm and 11.47pm
22 Month3 at 1.25am, 3.20am and 5.35am	22 Month3 at 2.16pm
	23 Month3 at 5.00am
24 Month3 at 10.00pm	24 Month3 at 5.54am
	25 Month3 at 5.34am
26 Month3 at 1.30am, 3.00am and 5.40am	26 Month3 at 11.41pm
	27 Month3 at 6.59am
	27 Month3 at 8.38am

Appendix C: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Rachel Parmee on 3 November 2020:

'HDC REPORT REFERENCE: C20HDC00374

1. Thank you for the request to provide clinical advice regarding the care provided by [Mayfair] to the late [Mr B] between 1 [Month1] and 27 [Month3]. In preparing the advice on this case, to the best of my knowledge, I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1985. Upon registration I worked as a RN in the Haematology ward at Christchurch Hospital. This included care of acutely ill elderly patients. In 1986 I engaged in study for a Diploma in Social Sciences (Nursing) and worked 2 nights a week in the Oncology Ward at Palmerston North Hospital. On return to Christchurch, I worked as a staff nurse in the Ear, Nose and Throat Ward and became Charge Nurse of that ward from 1987 through to 1992. I then moved to Dunedin and worked as a senior lecturer at Otago Polytechnic during the development of the Bachelor of Nursing programme. I completed my Master of Nursing at Victoria University in 1998. My thesis studied patient education and chronic illness. In 1999 I was appointed Charge Nurse of the Children's Unit at Dunedin Hospital. I returned to Otago Polytechnic in 2001 and was appointed Principal Lecturer and Programme Manager of the Postgraduate Programme in 2003. In 2005 through to 2006 I worked as a sole charge Practice Nurse in a local General Practice. In 2008–2010 I worked as Co-ordinator of Education Programmes for Southlink Health. In 2011 I moved to Christchurch where I worked as an RN in the Hospital wings of 2 large Residential Villages and a senior lecturer at Christchurch Polytechnic specialising in care of the elderly. In 2013, upon return to Dunedin, I worked as a Clinical Co-ordinator at Dunedin Hospital. In 2014, I worked as an Academic Advisor at Otago Polytechnic. In 2015 I worked as Nurse Manager at a local Rest Home. My current role is co-ordinating courses in the Enrolled Nurse programme at Otago Polytechnic. I am currently a member of the Nursing Council of New Zealand's Professional Conduct Committee.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr B] between [Month2] and [Month3] was reasonable in the circumstances and why. With comment on:

   1. The management of [Mr B's] pain level during dressing changes

   2. The frequency at which [Mr B] was turned and the documentation of this in the clinical notes

   3. The standard of wound care provided and the wound care documentation

   4. Any other matters that I consider warrant comment

For each question I am asked to advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.

c. How would it be viewed by my peers?

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

4. In preparing this report I have reviewed the documentation on file:

1. Letter of complaint dated 18 February 2020
2. [Mayfair's] response dated 30 April 2020
3. Clinical records from [Mayfair] covering the period 1 [Month1] until 27 [Month3]
4. Dr C's response and clinical records from [Month1] covering the period 1 [Month1] until 27 [Month3]
5. [Community and acute nursing care organisation's] response dated 2 June 2020
6. A copy of relevant policies from [Mayfair]

5. Background

[Mr B] was a resident at [Mayfair], admitted [in] 2012 and assessed as requiring hospital level care.

In [Month1], a gastro-intestinal outbreak occurred. [Mr B] vomited on 2 [Month2] and was placed in isolation.

On 8 [Month2] [Mr B] was reviewed by a General Practitioner and prescribed antibiotics for a suspected chest infection and diagnosed with a Cerebrovascular Accident (CVA). Around the same time a sacral wound developed into a pressure ulcer. This was initially assessed as stage 2, however, it deteriorated requiring specialist care input and oversight.

[Mr B] passed on 27 [Month3].

Review of Documents

6. The management of [Mr B's] pain level during dressing changes

[Mr B] was diagnosed as having an unstageable pressure area on his sacrum which developed from a small sacral wound in [Month2]. [Mr B's] GP [Dr C] prescribed Morphine to be administered 30 minutes before dressing changes. Her rationale for this included [Mr B's] aphasia (related to a stroke he suffered in [Month2]) and consequent difficulty verbally expressing pain and the likelihood that dressing changes would be painful.

The medication and wound care charts indicate that [Mr B] was not given regular pain relief prior to his dressings. In his response to HDC [the village manager] notes that while reviewing the administration records of the PRN Morphine in conjunction with the wound dressing chart it was noted that not all pre-dressing analgesia was given on a regular basis prior to dressings. This is also evident in the documentation provided.

a) What is the standard of care/accepted practice?

The standard of care is that prescriptions for any medication are followed unless there is a documented reason for not giving medication as prescribed such as patient refusal or inability to take medication. Medications prescribed PRN (as necessary or as required) are required to include a stipulation for the situation when the medication is to be administered.

In this case the charting (25 [Month2]) clearly states in the "instructions" column "pain, give at least 30 minutes prior to dressing change".

b) If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

There has been a severe departure in that the medication was not given as prescribed. This resulted in a painful intervention being carried out without ensuring the comfort of a vulnerable resident who was immobile and unable to verbally express pain. It is also noted in [the village manager's] response that [Mr B's] daughter's concerns about his pain were not considered by staff. This reinforces the severity of this departure in that the concerns of [Mr B's] advocate were not acknowledged.

c) How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

[The village manager] describes a number of interventions which have taken place as a result of his review of [Ms A's] complaint. These include ensuring that all staff adhere to the Pain Management policy with particular focus on pain assessment with non-verbal residents and adherence to prescribed medication instructions when undertaking any treatment likely to exacerbate pain. I believe these to be appropriate interventions to prevent a similar occurrence.

7. The frequency at which [Mr B] was turned and the documentation of this in the clinical notes

[Mr B] suffered a CVA in [Month2] which resulted in immobility and aphasia. He also had an unstageable pressure area. Each of these factors necessitate the implementation of a pressure relieving plan. The care plan, last updated on 2 [Month3], includes instructions for regular changes to position to reduce time sitting on his sacrum to allow healing. It also notes the use of an air mattress and 2 hourly

turns while [Mr B] was in bed. In his response [the village manager] notes that while there were discrepancies in the documentation on the turning chart (12 days in [Month2] and 6 days in [Month3] where there were no recordings on the turning chart) there was reference to turning and position changes in the progress notes. The records provided substantiate this information.

While it is evident that [Mr B] was turned regularly as required in the care plan and that this was recorded in the progress notes the turning charts were not maintained at all times.

a) What is the standard of care/accepted practice?

The accepted standard is that all documentation is accurate and maintained to reflect the care that was actually provided.

b) If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

I do not believe there was a departure in terms of the care provided to [Mr B] in relation to pressure area prevention. However, there was a mild departure in terms of maintaining documentation.

c) How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

It needs to be reiterated with nursing staff that all documentation meets the required standard.

8. The standard of wound care provided and the wound care documentation

Review of the progress notes indicates that [Mr B] developed a sacral wound between 22nd [Month2] when it was documented as a dry wound and 26th [Month2] when it was described as broken down and increased in size. On 29th [Month2] it was described as an ulcer and on the 30th [Month2] as a Stage 2 pressure wound. He was seen by a GP on the 5th [Month3] when a wound swab was taken, and antibiotics prescribed. The GP also referred [Mr B] for District Nurse wound care advice. The wound continued to deteriorate and became classified as unstageable. [Mr B's] usual GP [Dr C] saw him on the 10th [Month3] and made referrals to a wound care specialist and Plastics registrar.

In his letter [the village manager] makes the following comment about wound documentation:

A wound chart was commenced on the 24th [Month1] for Moisture Associated Skin Damage. Two more wound charts were commenced on the 29th [Month2] and a fourth on the 30th [Month2], all for what appear to be the same wound. It is unclear

which chart was being followed. The MASO chart was discontinued on the 7th [Month3] because the wound had developed into a pressure injury. The two charts titled Pressure Injury Stage 2 were discontinued on the 13th [Month3] following the CNS specialist assessment and direction.

a) What is the standard of care/accepted practice?

Accepted practice is that the facility Pressure Injury and Prevention and Management Policy and Wound Management Policy are followed particularly in terms of documentation of wound assessment and treatment. A HealthCERT notification is made for pressure injuries Stage 3 and above. A referral is made to a wound care specialist for such pressure injuries.

b) If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

I believe that there was a moderate departure in terms of consistency and accuracy of documentation. It is also noted that there were 2 days when there was no documentation that the wound had been dressed. However, I believe that appropriate and timely referrals to District Nursing and Wound care Specialist) and notifications (HealthCERT) were made in line with the facility policies. My greatest concern is the issue of inconsistent pain relief which is addressed above.

c) How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

I understand that RNs have been required to complete further education on wound assessment, management, and charting. This is I believe appropriate for preventing a further occurrence.

9. There are no other matters that I believe require comment.

Rachel Parmee RGON, MA (Nursing)'

The following further advice was obtained from RN Parmee on 24 October 2022:

'**C20HDC00374**

Thank you for the opportunity to provide further advice in the case of the late [Mr B] in relation to the care provided by [Mayfair] between 1 [Month1] and 27 [Month3].

I am asked to advise:-

1) Whether [Mayfair's] comments change any aspects of my initial advice;
2) Whether there are any other matters in this case that I consider warrant comment; and
3) Any recommendations that I could think of for future improvements at [Mayfair].

In their response to the Commissioner Mayfair provides detail of, among other information, their corrective action plan, records and detail of staff training, the process and outcome of their internal investigation and responses to my initial findings (3/11/2020).

In completing this report, I have reviewed my initial response along with the documentation provided by Mayfair.

The response covers concerns raised by [Mr B's] daughter around pain management, wound care and communication.

In my original advice I noted that appropriate measures and education had been put in place to ensure that [Mr B's] experience of inappropriate pain management would not be repeated. The information subsequently provided supports my initial comment and recommendations.

In terms of wound care provided I am satisfied that sufficient remedial education around documentation of wound assessments and interventions has taken place and believe that this and further education around wound care will prevent further recurrences of the issues, mainly documentation, which arose around [Mr B's] wound care.

Finally, it is clear that extensive education of all staff has taken place around communication.

In summary, I believe that the response provided by Mayfair acknowledges the discrepancies identified in my initial response and that appropriate measures have taken place to prevent future occurrences.

Please do not hesitate to contact me if you require further information.

Yours sincerely

Rachel Parmee'

The following further advice was obtained from RN Parmee on 19 June 2023:

'Re: HDC REPORT REFERENCE: C20HDC003

Thank you for the opportunity to provide further advice for this case.

I have been provided with the following information:

1. The complaint dated 26 February 2020
2. My Initial EA dated 3 November 2020
3. My second EA dated 26 October 2022
4. Additional Information/response from [Dr C]:
   a. E case medical notes dated 10 May 2023
   b. Triage and referrals dated 8 May 2023
   c. Text messages: dated 7 May 2023
   d. Notes held at practice dated 7 May 2023

I am asked to review the additional response/supporting documents from [Dr C] and advise whether any of the comments change my advice.

I believe that the medical notes, triage and referrals, text messages and practice notes are all consistent with processes and events as discussed in my previous advice.

I do not believe that this information in any way alters my advice.

Please feel free to contact me if you require further detail.

Yours sincerely

Rachel Parmee'