Oceania Care Company Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01049)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly man, who was paralysed and had dementia, at a residential aged-care facility owned and operated by Oceania Care Company Limited (Oceania). Previously the man had lived at home, where his wife was his primary caregiver. During the man's admission to the facility, he developed serious pressure wounds, and required hospitalisation for urinary tract infections. Sadly, he died approximately six months after admission to the facility.

2. The Deputy Commissioner noted that without appropriate support and interventions, the man's health had the potential to deteriorate rapidly, and he was at risk of developing complications. She stated that the facility "accepted [the man] into their care and as such they then assumed responsibility for meeting his needs and keeping him safe".

3. The Deputy Commissioner found that the following issues contributed to a failure to put in place effective actions to prevent and manage the man's serious pressure injuries and infections, and that therefore Oceania breached Right 4(1) of the Code:

   a) The assessment of, and care planning for, the man were inadequate, in that there was a lack of initial consultation with his wife, an interRAI assessment was not completed in a timely manner, and there was a lack of documented assessment of his pressure-injury risk or plans to mitigate that risk.

   b) Documentation and evaluation of wound progress was lacking, and the notification to HealthCERT of the man's buttock wound was inaccurate and delayed.

   c) Fluid balance monitoring was not completed from the outset, despite the man having a suprapubic catheter in place, which put him at risk for developing an infection.

   d) There was a failure by multiple staff to follow Oceania policies and procedures.

4. The Deputy Commissioner also criticised the facility's Restraint Coordinator for allowing the use of a restraint (a reclining arm chair) that was unsuitable for the man and was not an approved restraint in line with Oceania policy.

5. The Deputy Commissioner recommended that Oceania apologise to the man's family; arrange training on resident care planning and pressure area risk assessment and management; conduct an audit of completion of long-term person-centred care plans and monitoring forms; review its restraint policy to provide guidance on pressure relief monitoring while restraints are in use; and provide evidence that the facility staff are aware of the statutory obligations for reporting pressure areas.

6. Oceania was referred to the Director of Proceedings to determine whether proceedings should be taken.

Complaint and investigation

7. The Commissioner received a complaint from Mr B about the services provided by Oceania Care Company Limited to his father, Mr A. The following issue was identified for investigation:

- *Whether Oceania Care Company Limited provided Mr A with an appropriate standard of care between Month2[1] and Month8 2018.*

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

9. The parties directly involved in the investigation were:

Mr B	Complainant/consumer's son
Oceania Care Company Limited	Provider

10. Further information was received from:

Mrs A	Mr A's wife
RN B	Provider/Clinical Manager
RN C	Provider/Restraint Coordinator
District health board	
The Ministry of Health	
The Nursing Council of New Zealand	

11. Also mentioned in this report:

RN D	Registered nurse
RN E	Registered nurse
Dr F	General practitioner
Ms G	General Manager Nursing and Risk
Ms H	Clinical and Quality Manager

12. Independent expert advice was obtained from RN Rachel Parmee (Appendix A).

Information gathered during investigation

Introduction

13. This report concerns the services provided to Mr A at a residential care facility (the rest home) owned and operated by Oceania Care Company Limited (Oceania), between his admission to the rest home in Month2 and his admission to the public hospital in Month8.

[1] Relevant months are referred to as Months 1–10 to protect privacy.

Mr A

14. At the time of Mr A's admission to the rest home, he was in his eighties. He had T4 paraplegia[2] (arising from an accident 26 years previously), frontal lobe dementia,[3] and chronically low blood pressure. To assist with the management of his continence, Mr A had both a suprapubic catheter[4] and a colostomy.[5]

15. Prior to Mr A's admission to the rest home, his wife, Mrs A,[6] had been his primary caregiver. Mr A's son, Mr B, told HDC that Mr A and his wife had managed his paraplegia for 26 years with relatively little help. However, in the three months prior to his admission to the rest home, Mr A had required increased assistance from carers.

16. On 3 Month1, the district health board (DHB) completed an interRAI assessment[7] of Mr A's needs. The assessment noted that Mr A's cognitive skills for daily decision-making were severely impaired, and that he was totally dependent for many activities. It also noted that he required maximal assistance with toileting, and that he could move in his wheelchair with supervision. Mr A's family clarified that any supervision was to ensure that he did not go too far, too fast.

17. The assessment stated that Mrs A was struggling to manage Mr A's behaviours associated with frontal lobe dementia, and that she was coming to the end of being able to manage Mr A at home, and soon he would require residential care.

18. Following the assessment, the decision was made for the rest home to provide residential and respite care for Mr A.

Rest home

19. At the time of these events, the rest home was certified to provide hospital-level and rest-home care (excluding dementia care) and had a service contract with the DHB. In 2017, a routine audit of the rest home against the Health and Disability Services Standards found the following three areas in which a standard was attained only partially:

1. A pressure injury was not reported to HealthCERT in accordance with statutory obligations.
2. interRAI reassessments and risk reassessments were not completed consistently within the required six-monthly timeframes.
3. A high-risk assessment for a resident with a pressure injury had not been followed through with appropriate interventions.

[2] Loss of ability to use the legs caused by damage to the spinal nerves.
[3] A type of dementia connected with shrinkage of the frontal lobes of the brain.
[4] An artificial flexible tube used to drain urine directly out of the bladder.
[5] A surgical procedure that brings one end of the large intestine out through the abdominal wall. This allows faeces to leave the body through an artificial hole in the skin and into a pouch attached to the patient.
[6] Mr B advised HDC that Mrs A held an enduring power of attorney (EPA) for Mr A.
[7] A tool that provides a clinical assessment of medical, rehabilitation, and support needs and abilities, and self-care for clients who require home and community support services.

20. At the time of these events, RN B was the Clinical Manager at the rest home, and another nurse was the Business and Care Manager. In response to the "information gathered" section of my provisional report, Mr A's family explained that they were told by the Business and Care Manager that RN B would be "responsible for the medical care of the patients". RN B told HDC that her role was managerial and supervisory, and that she did not have day-to-day direct contact or care of patients unless the nursing staff asked for or required her supervision. RN B said that she maintained a spreadsheet to record matters such as due dates for interRAI assessments and care plans, so that she could warn the staff who were responsible for completing them if they were due. RN B stated:

> "[Mr A] was a very high needs patient, with a strong sense of independence which often led to difficulty for staff to implement prescribed care. [The rest home] was able to provide the care that he needed, but he was one of the higher needs patients at the facility."

21. There were two charge nurses at the rest home. RN C was the Charge Nurse for the rest home, and RN D was the Charge Nurse for the hospital wing. RN B told HDC that there was always a registered nurse rostered on to the hospital wing, and two to five healthcare assistants were rostered to assist the nurse, depending on the time of day.

Admission to the rest home

22. On 9 Month2, Mr A was admitted to the rest home for respite hospital-level care. Oceania told HDC: "A comprehensive assessment of his needs prior to admission was not completed. Our staff rely on the Community InterRAI Assessment as being a credible record." RN B told HDC that her role for admissions was to check that the interRAI assessed level of care could be met by the rest home, and not to assess Mr A's needs directly herself.

23. Oceania told HDC: "Staff at [the rest home] did not have the skills to provide the expected quality of care to [Mr A] who had a complex medical history." It stated that it would have expected the Business and Care Manager and the Clinical Manager, who were responsible for admitting residents, to consult Oceania's Clinical and Quality Team about whether to admit Mr A. However, they did not. Oceania further stated that had the Team been consulted, it would have asked the facility either to decline admission or state the additional resources it would require to care for Mr A appropriately.

24. RN B explained that the DHB's Older Persons' Mental Health team often considered that it was more suitable to transfer a person with dementia from a home-based care situation to a care facility with hospital-level care, rather than to a dementia unit, because it is an easier transition for the resident and their family.

25. RN B stated:

> "[Mr A's] admission to [the rest home] was in line with the facilities that [the rest home] had available — [Mr A] had all the standard support network involved, such as [the DHB Older Persons' Mental Health], an external needs assessor and a supportive family. All this meant that [the rest home] was able to provide the services that [Mr A]

> required. The Oceania head office never required the team at the facilities to check clinical decisions, needs assessments, or care plans."

Care planning

26. On the day of Mr A's admission (9 Month2), an initial person-centred care plan was completed by RN E. The plan noted Mr A's medical diagnoses of frontal lobe dementia, hyponatraemia,[8] hypotension, and paraplegia. However, initially it did not record instructions from Mrs A, who had been his primary caregiver for 26 years, for how to manage his high pressure injury risk or his fluid requirements. In response to the information gathered, Mr A's family commented that they considered that this was a "cookie-cutter" assessment that was not sufficient to identify and record Mr A's needs.

27. Mr B told HDC that his father's fluid intake monitoring was always a concern for Mrs A, who took very seriously the instructions from the spinal unit that Mr A was to consume 2–3L of water per day. Mr B stated: "[I]t seemed to be a struggle to get Oceania to take this aspect of his care seriously." He also told HDC that in the 26 years that his mother and father were at home, Mr A never had any pressure injuries, and, aside from one bladder stone problem, no urinary tract infections. Mr B stated:

> "The day [my father] was admitted there appeared to be limited information written down regarding his needs; the desire seemed to be to tick off boxes on a form and unfortunately [he] did not fit into any of their boxes."

28. The initial person-centred care plan was updated on 11 Month3, following a meeting between RN B and Mrs A. The update included recording the use of heel protectors and giving Mr A two-hourly turns to manage his compromised skin integrity caused by his decreased feeling/circulation in his lower limbs. It also noted that Mr A was on strict fluid intake monitoring, and a chart for this was put in place. In response to the provisional opinion, Oceania noted that the initial person-centred care plan records that Mr A had a high pressure injury risk, and checked boxes on the plan indicate that a pressure-relieving cushion and mattress were used. However, it is not clear to HDC whether this information was recorded on admission or at the time the plan was updated. In response to the information gathered, Mr A's family said that the heel protectors referred to were never used.

29. RN B told HDC that when a patient is admitted under respite care, only an initial/interim person-centred care plan is required. Mr A changed from being a respite-care resident to a permanent resident at the rest home on 5 Month3.[9] The Oceania "Person Centred Care Planning Policy (September 2017)" states: "By three weeks of the resident's admission date, the Person Centred Care Plan is developed." However, Mr A's long-term person-centred care plan was not completed until 24 Month5 (11 weeks later). In response to the provisional opinion, Oceania clarified that if a respite care resident is still at the facility after three weeks, a long-term person-centred care plan is to be completed at that time.

[8] Low sodium concentration in the blood.

[9] According to the Resident Admission Agreement. RN B told HDC that Mr A became a permanent resident on 11 Month5, but the information provided to HDC does not provide evidence of this.

30. An interRAI long-term care assessment was completed for Mr A on 11 Month5 by RN D. Oceania told HDC that "[Mr A] should have had an interRAI assessment completed within the first month of placement to facilitate a more appropriate care placement".

Use of restraint

31. Oceania's "Restraint Minimisation and Safe Practice Handbook and Policies" document states that Oceania is committed to minimising the use of restraint within the clinical setting, whilst maintaining safety of residents and staff. The document establishes that only forms of restraint approved by Oceania may be used in any facility. Oceania's four approved forms of restraint are: holding a person during an emergency, bed safety rails, chair lap-belts (including on wheelchairs and lounge chairs), and chair briefs.[10] RN C was the Restraint Coordinator at the rest home.

32. In the days immediately following his admission, Mr A expressed displeasure with his confinement to the rest home. On 10 and 11 Month2, he attempted to leave the premises, and this raised concerns about his safety. On 11 Month2, Mr A's GP, Dr F, advised that Mr A should be kept seated in a reclining chair (rather than in a wheelchair) to prevent him from trying to leave the rest home.

33. On 15 Month2, RN C and Mrs A signed a restraint consent form that provided for Mr A to be placed in a recliner chair so that he "[could not] get up without assistance". On 18 Month2, Dr F co-signed the form.

34. Mrs A told HDC that she had recommended Mr A be placed in a wheelchair with small wheels to limit his mobility, and that she signed the form on the understanding that both options would be utilised (i.e., the recliner chair and a wheelchair with smaller wheels). In response to the information gathered, Mr A's family stated that these options were agreed to only on the understanding that pressure relief would be provided by staff.

35. On 15 Month2, RN E filled in and signed a restraint assessment authorisation, plan, and consent form. She wrote on the form that Mr A had been "[t]rying to wheel himself in wheelchair & go out of the facility (wandering)". She noted that staff would use a "recliner chair" as a strategy to address this problem, with the expected outcome being "[t]o avoid wandering episode and keep safe". She documented that while Mr A was in the recliner he was to be observed and monitored at least every hour.

36. On 21 Month2, RN C filled in and signed a restraint/enabler evaluation form. She noted that the recliner chair restraint created risks of pressure injury and isolation. She documented that there were no future options to avoid its use, and that the restraint meant that staff could know Mr A's whereabouts.

37. RN C told HDC that staff decided to consider the recliner chair as a restraint, even though it was not an approved form of restraint by Oceania, to ensure Mr A's safety, and that regular monitoring checks were in place. She stated that the recliner was used for only approximately two hours at a time, and was phased out gradually as Mr A settled in.

[10] A device for securing residents to a chair.

38. RN B told HDC:

> "The recliner chair restraint for [Mr A] was implemented while I was on leave. All staff were trained in restraint, and knew that there were only three restraints (of which recliner chair was not one). Therefore I would have expected that while I was away [RN C] and [the nurse], who took over my responsibilities, would have queried the use of the recliner chair. When I came back from leave, I recall querying the restraint. I made it clear that staff could only put him in the recliner chair if he was asked and he said that it was okay."

39. Oceania told HDC that "[t]he documentation indicates the family were happy with this decision [although] the restraint used is not an approved Oceania restraint", and that "[n]o input or advice was sought by [rest home] staff from Oceania Healthcare Clinical and Quality team regarding the use of a non-approved restraint".

40. Bed rails with covers were also utilised for Mr A from 17 Month4 to prevent falls out of bed. Restraint documentation was completed in relation to this form of restraint, and restraint monitoring forms were completed for both the bed rails and the recliner chair restraints.

Wound care

41. While at the rest home, Mr A developed pressure injuries, which are detailed further below. Mr B told HDC that when the option of restraint in a recliner chair was discussed with Mrs A:

> "She made it clear that regular pressure relief would need to be provided for [Mr A] … I cannot stress how much this was repeated to the home that regular pressure relief was required. It was obviously hand[l]ed very poorly in light of the wounds my father subsequently suffered."

42. There is no evidence in the clinical notes of a Braden Scale score[11] being utilised at any time for Mr A.

Heel injuries

43. Mr A was found to have pressure areas on his heels on 29 Month2. Progress notes written that day by a nurse state that a healthcare assistant told him about blisters on Mr A's heels. The nurse wrote: "[C]ommenced on 2 hourly repositioning. Dressing done for protection as no heel protectors available." A short-term care plan commenced on this date noted that the wounds were stage two.[12] Mr A's pressure injuries were brought to the attention of HealthCERT on 5 Month3,[13] and a pressure injury care plan was

[11] A tool used to predict the risk of a resident suffering a pressure injury.
[12] Partial thickness skin loss.
[13] Section 31(5) of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about any health and safety risk to residents. Currently, HealthCERT requires residential aged-care providers to report all pressure injuries at stage 3 and above.

commenced on 7 Month3, and a referral sent to the DHB wound care nurse on 8 Month3 seeking input.

44. Mrs A raised concerns that initially she was not informed about the pressure sores on Mr A's heels, but instead noticed them after a dressing on his heel slipped and revealed the damage. She said that she had been told that the dressings were for protection only, not that there were actual wounds. In response to the information gathered, Mr A's family raised concerns that the heel sores were identified by Oceania only once they had blistered.

45. A serious or sentinel event investigation form was filled out on 12 Month3 by RN D. This documented that Mr A's heel wounds were unstageable.[14] The form states that a wound care plan was commenced after consultation with the GP and wound care specialist nurse. It also stated that there was a discussion with Mrs A, who advised that she had (in the past) turned Mr A onto his side at night. RN D recorded that she spoke with night staff, who said that Mr A had resisted being turned over on his side at night, so "modified two hourly turns were being completed". RN D recorded that a pressure mattress and heel protectors were put in place.

46. The pressure injury care plan has a space to record at least weekly evaluations of the wound and care plan. This was filled in regularly by registered nurses, but generally the comments documented relate only to the dressings being changed, or the type of dressing used, rather than an evaluation of the condition of the wounds. However, a pressure injury assessment and monitoring form was filled in regularly, which recorded the size of the wounds, the wound bed, and the condition of the area around the wounds.

Buttock injury

47. On 15 Month4, RN D documented that Mr A had redness on both buttocks. A resident incident/accident reporting form was completed by RN D on 16 Month4. This stated that RN B, Mrs A, and the GP were informed, and a pressure injury care plan was completed.

48. Documentation for the buttock pressure areas was recorded on the same pressure injury care plan as used for the heel wounds. This did not include evaluation of the buttock wounds; rather, it recorded the date of dressing changes and the type of dressing used. These recordings commenced on 18 Month4. A pressure injury assessment and monitoring form was not commenced until 12 Month7.

49. On 6 Month6, it was documented by RN D that Mr A's dressings were changed and his wound had offensive discharge, so a wound swab was sent to the laboratory. He was seen by a district nurse on 9 Month6.

50. On 10 Month6, Mr A was taken to the public hospital for a separate health issue, and was monitored in the ED before being discharged. While in the ED it was noted that he had a "very deep sacral pressure sore, very offensive smelling" that could not be staged. The consultant recorded in the discharge summary:

[14] The depth cannot be determined, as the base of the pressure injury is covered by slough and/or eschar.

> "I have spoken to rest home and strongly recommended district nurses have very close follow up/review of his pressure areas; and also recommended GP follow up in a few days time."

51. On 13 Month6, the swab result came back as MRSA positive.[15] On 14 Month6, a nurse completed a short-term care plan for the wound infection, which included instructions to administer antibiotics for 10 days (as per GP instructions), continue two-hourly turns, watch for further redness, change the dressing "as per [wound care plan]", and monitor Mr A's temperature.

52. On 13 Month7, a further short-term care plan was commenced for the buttock wound, and this included the same instructions as the previous short-term care plan.

53. A notification of the buttock pressure injury was sent to HealthCERT on 16 Month7. This stated that the wound was unstageable, and that it was identified on 7 Month5. It also specified that a wound nurse specialist had assessed the pressure injury on 26 Month6.

District nurse involvement

54. Mr A was seen by the DHB district nurses in relation to his pressure areas on 9 Month6, 15 Month6, 22 Month6, 29 Month6, 5 Month7, 12 Month7, 19 Month7, 26 Month7, 3 Month8, and 16 Month8. RN B clarified that the DHB wound specialist nurse was based at the allied health hub, and would direct how district nurses managed wound care treatment in facilities. She stated:

> "[I]t was the District Nurses that attended the rest home to assess the wounds and recommend the care plan when a fax had been sent for request of Wound care specialist nurse assessment."

55. Oceania told HDC: "Oceania … did not consult well with the district nursing service and nurse wound specialist prior to 15 [Month6]."

Urinary tract infection

56. Mr A did not have fluid balance monitoring commenced when he was admitted to the rest home. RN B told HDC:

> "[The rest home] did not carry out specific fluid balance monitoring, unless there was a clinical need for this. Standard practice was to record food and fluid in the progress notes. [Mr A] initially did not require fluid balance monitoring."

57. On 17 Month4, RN D changed Mr A's catheter (this was done routinely). RN D noted that the "catheter was partially blocked and very offensive and [there was] pus in his urine". A urinary tract infection (UTI) was confirmed, and RN D notified Dr F, who saw Mr A later that day. Dr F queried whether Mr A had urosepsis,[16] and recommended that he start a

[15] Methicillin-resistant *Staphylococcus aureus* is a type of bacteria that is resistant to several antibiotics.
[16] Sepsis caused by a urinary tract infection.

course of antibiotics, have paracetamol as needed, and be commenced on a fluid balance chart.

58. A fluid balance chart was started that evening for Mr A, and appears to have been filled in by multiple staff. The daily charts are often incomplete, and the daily totals of fluid input and output were not recorded regularly or entered into the progress notes regularly.

59. Mr A was admitted to the public hospital on 24 Month4 for treatment of *E. coli* sepsis as a result of his UTI. He was discharged back to the rest home on 28 Month4 with a further five days of antibiotics and a plan to seek further medical advice if his condition worsened.

Subsequent events

60. Mr A was admitted to the public hospital again on 19 Month8 with pneumonia, an increased heart rate, fluid on his lungs, a further UTI, and a stage four pressure area on his sacrum.[17] While in hospital, his family arranged for him to be discharged to a different rest home, which occurred on 29 Month8. Sadly, Mr A died shortly afterwards on 31 Month8.

Further information — Oceania

61. Oceania told HDC that eight registered nurses, one enrolled nurse, and 23 healthcare assistants were involved in Mr A's care.

62. With the exception of RN C, none of the registered nurses referred to in this report still work at the rest home.

63. Oceania advised that after these events it initiated the following:

a) A "Resident Entry to Services Policy" was introduced. This policy is to ensure Oceania residents are "accepted to the facility according to their accepted level of care".

b) Annual Oceania study days are now delivered as required so that all staff can attend them.

c) An electronic resident information system is being implemented at all Oceania facilities. Oceania stated that "this will provide transparency to key staff overseeing care delivery outside of the facilities".

d) The Oceania restraint policy was reviewed in 2018.

64. Oceania stated: "Oceania Healthcare [rest home] staff did not meet Oceania's care standards or [the family's] expectation. I sincerely apologise for this."

Further information — the family

65. Mr B stated:

> "The most alarming thing about [the rest home] was their assurance that they knew how to care for a patient like [my father] whereas clearly they did not. When things started going wrong and my mother tried to talk to them about the problems, she was

[17] Full thickness tissue loss.

not listened to and there was clearly a lack of interest in trying to talk to her … [T]here seemed to be limited information across the whole site and things appeared poorly run."

Responses to provisional opinion

66. Mr A's family, Oceania, and RN C were given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, their comments have been incorporated into the report.

67. RN C advised that she accepted the provisional findings. She stated: "I acknowledge I made decisions that may have adversely impacted on [Mr A's] care and not followed policies and processes but at the time it was to try and maintain his safety." She commented that the registered nurses in charge of each shift were responsible for ensuring that pressure care and monitoring were maintained.

68. Oceania acknowledged that there were deficiencies in the care provided to Mr A. It also acknowledged the considerable distress caused to Mr A's family, and stated that it deeply regrets the events that occurred while Mr A resided at the rest home.

69. Oceania advised that in late 2019, a comprehensive independent review of its clinical services resulted in a new clinical governance strategy to strengthen the quality of clinical services provided, and provide appropriate structures to support these services. This includes the appointment of Regional Clinical Managers, a National Quality, Compliance and Audit Manager, and an Education and Research Manager. It said that it has also strengthened the Clinical Manager's job description to clearly set out the responsibilities for oversight of provision of clinical care.

70. Oceania explained that at the time of RN B's employment, her job description clearly stated that she would be responsible for overseeing care delivery, would be responsible for ensuring that training of staff was up to date and relevant to the cares required by the residents, and that assessments, including interRAI, care plans, and evaluations were up to date.

71. Oceania noted that the initial person-centred care plan was signed by Mrs A on 9 Month2, "indicating involvement in the care planning process".

72. Oceania advised that the following further changes have been made to its service:

a) Its "Person Centred Care Planning Policy" was reviewed in January 2020 and has been updated to include the direction that staff are to gain information from a range of sources, including family/whānau, and that the care plan will be signed off by the resident or a family representative.

b) It has provided additional staff training on resident care planning. Across Oceania, in 2019, 95% of registered nurses had completed this training. By December 2019, 40% of the rest home's registered nurses had attended the training.

c) Pressure injury assessment, prevention, and management is included in the annual mandatory study days for registered nurses. Oceania's annual wound comprehension has been reviewed to ensure that there is a component of pressure injury prevention, and 79% of clinical staff at the rest home have completed this new comprehension.

d) Recording of pressure injuries is undertaken monthly as part of its data collection and analysis. Since this complaint, notifications of grade three and above pressure injuries have been sent to the Regional Clinical Manager and the National Quality, Compliance and Audit Manager, and then the Regional Clinical Manager is responsible for further actions.

e) All nursing and caregiving staff undertake annual study days, which include the topic of observation and monitoring.

73. In response to the information gathered, Mr A's family stated that the way his pressure sores developed demonstrated that Mr A was in the recliner chair for longer than two hours at a time, without pressure relief. They noted that the use of the chair was not phased out, but had to be stopped as Mr A required bed rest for the pressure sores.

Opinion: Oceania Care Company Limited — breach

74. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), Oceania had a duty to provide its residents with services of an appropriate standard. The New Zealand Health and Disability Service Standards require organisations (including rest homes) to ensure that their services are managed in an efficient and effective manner, to ensure the provision of timely and safe services to consumers.[18] Overall, I consider that Oceania holds primary responsibility at a systems level for the poor standard of care provided to Mr A in the areas discussed in this opinion.

75. Oceania told HDC that eight registered nurses, one enrolled nurse, and 23 healthcare assistants were involved in Mr A's care at the rest home from Month2 to Month8. My expert advisor, RN Rachel Parmee, commented:

> "The responsibility for the shortcomings identified in [Mr A's] care lay with all Registered Nurses involved in his care including the Clinical Manager, Business Manager, Charge Nurses and Registered Nurses."

76. As the employing authority of these staff members, I consider that overall Oceania is responsible for the patterns of poor service delivery demonstrated by the multiple staff members involved in Mr A's care.

[18] NZS 8134.1.2:2008 at 2.2.

77. While Oceania told HDC that staff at the rest home did not have the skills to provide the expected quality of care to Mr A, RN B said that Mr A's admission was in line with the facilities that the rest home had available.

78. Because of Mr A's medical conditions, his care could have been suited to either a dementia unit or a hospital-level facility. RN B explained that the DHB's Older Persons' Mental Health team often considered that it was more suitable to transfer a person with dementia from a home-based care situation to a care facility with hospital-level care, rather than to a dementia unit, because it is an easier transition for the resident and their family. I accept this with the caveat that there is regular review to gauge the suitability of the arrangement for both the person with dementia and the other residents receiving hospital-level care at the time.

Assessment and care planning

79. Mr A was admitted to the rest home for respite care on 9 Month2. He had been paraplegic for 26 years following an accident, and was experiencing worsening frontal lobe dementia. Up until 9 Month2 he had been cared for at home by Mrs A. Oceania's assessment and care planning of Mr A was deficient in several respects.

80. First, Mr A's initial care plan, completed at the rest home on 9 Month2, did not record input from Mrs A until a month later. RN Parmee advised that in all cases there should be input from the patient and family members. She said that given that Mr A had a long-term condition that he and his wife had managed for 26 years, "it was vital that [Mrs A] provided information on the prevention of pressure injuries and that this be included in the assessment and care plan". In response to the provisional opinion, Oceania noted that Mrs A signed the initial care plan, "indicating involvement in the care planning process".

81. I do not agree that Mrs A's signature on the initial care plan showed that she had meaningful involvement in the initial care planning process. Instructions and input from Mrs A were not recorded in the care plan until a month later. In my view, it was imperative that the rest home incorporate Mrs A's input into the initial care planning for Mr A, given that she had been his primary caregiver for 26 years and would have had important insights in how to manage his pressure area and bladder infection risks effectively. However, there was inadequate documented evidence of consultation with Mr A's family around his particular care needs.

82. I am concerned that Mrs A's input was not recorded until 11 Month3, over one month into Mr A's respite placement. As RN Parmee noted, by the time consultation with Mrs A occurred, Mr A already had pressure injuries.

83. Second, Mr A had an interRAI assessment completed in the community on 3 Month1, but a further interRAI assessment was not completed at the rest home until 11 Month5. RN Parmee advised that an interRAI assessment should have been completed within the first month of Mr A's placement in the facility. She stated:

> "An interRAI assessment was also necessary to properly assess [Mr A's] care needs while at the rest home. In the absence of such an assessment the facility did not provide appropriate care in terms of pressure area management, infection prevention and appropriate use of restraint."

84. RN Parmee also commented: "This not only meant a compromise in the quality of care [Mr A] received but also contravention of District Health Board requirements for interRAI assessments."[19] I agree that Mr A should have had an interRAI assessment carried out earlier in his care at the rest home. In my view, this fundamentally important tool for Mr A's care planning was not completed in a timely manner.

85. Third, Mr A's permanent admission commenced on 5 Month3, but his long-term person-centred care plan was not completed until 11 weeks later on 24 Month5. This contravened rest home policy, which required the plan to be completed within three weeks of a resident's admission date. I am critical of the delays in completing both the interRAI assessment and the long-term care plan.

86. Lastly, Oceania's initial assessment and care planning failed to identify Mr A's pressure injury risk adequately, or put measures in place to prevent pressure injuries. RN Parmee noted that Mr A had three major risk factors for pressure injuries: a 26-year history of paraplegia, frontal lobe dementia, and advanced age. RN Parmee advised that the prevention of Mr A's pressure injuries needed to be based on his needs as a person with paraplegia, and suggested that a tool such as a Braden score could have provided a regular assessment of his pressure-area risk. However, there is no evidence of regular assessment and scoring of Mr A's pressure-area risk.

87. There is also no evidence of a plan to prevent pressure injuries. As RN Parmee notes, the care plan did not require areas at risk for pressure injuries, such as heels and buttocks, to be checked for signs of pressure. There was also no requirement that Mr A be assisted to change position, including during the 30-minute restraint checks, and staff used bandages rather than heel protectors on 29 Month2. I am concerned at the lack of documented initial assessment of Mr A's pressure-area risk, or plan to prevent or mitigate that risk from the time he was admitted to the rest home. This was particularly important for Mr A because of his major risk factors for developing pressure areas.

88. In response to the provisional opinion, Oceania noted that the initial person-centred care plan records that Mr A had a high pressure injury risk, and the plan has boxes checked indicating that a pressure-relieving cushion and mattress were used. However, it is not clear whether this information was recorded on admission or at the time the plan was updated with Mrs A's input on 11 Month3, and I note that RN D documented that a pressure-relieving mattress was put in place on 12 Month3, after Mr A's heel wounds were found to be unstageable. I therefore maintain my criticisms in the above paragraphs about the failure to identify and mitigate Mr A's pressure-area risk adequately.

[19] The 2017 Aged Related Residential Care Services Agreement states: "[E]ach Resident has an interRAI [long-term care facility] assessment completed within 21 days of admission to your Facility, in order to inform the Resident's Care Plan."

Restraint

89. On 15 Month2, RN C and Mrs A signed a restraint consent form that provided for Mr A to be placed in a recliner chair, to prevent him trying to leave the rest home in his wheelchair. RN E filled in a restraint assessment authorisation, plan, and consent form on the same day, and RN C filled in an evaluation form on 21 Month2, which referenced the risk of pressure injury.

90. I am critical that the recliner chair was used to restrain Mr A, when this was not an approved restraint according to Oceania policy. In addition, as RN Parmee advised, the recliner chair was an inappropriate form of restraint in this case, as its use contributed to Mr A's development of pressure injuries, given that there were no instructions to staff to undertake regular pressure relief.

91. I am concerned that despite the acknowledged risk of pressure injury whilst using the recliner chair, there are no documented instructions to staff on how to mitigate this risk (eg, by changing Mr A's position). I also note that Mrs A made it clear to the rest home that regular pressure relief would need to be provided whilst using the recliner chair, but there is no evidence that there was monitoring of Mr A's pressure areas whilst he was in the recliner chair.

92. Oceania noted that no input or advice was sought from the Oceania Healthcare Clinical and Quality team regarding the use of a non-approved restraint. However, Oceania's "Restraint Minimisation and Safe Practice Handbook and Policies" did not provide guidance on what to do in circumstances where a non-approved restraint was being considered.

Wound care

93. Mr A was found to have pressure areas on his heels on 29 Month2. Initially these were noted to be stage two, and the nurse wrote in the progress notes: "[C]ommenced on two hourly repositioning. Dressing done for protection as no heel protectors available." The heel wounds were noted to be unstageable on 12 Month3.

94. On 15 Month4, Mr A was found to have redness on both buttocks. A pressure-injury care plan was started the next day, but an assessment and monitoring form was not commenced until 12 Month7. The buttock wound was found to have offensive discharge on 6 Month6, so a swab was taken. This later returned a positive result for MRSA. On 10 Month6, Mr A attended the public hospital for a separate health issue, and the severity of his buttock wound was noted. The consultant noted in the discharge summary a strong recommendation for close follow-up by district nurses.

95. The documentation provided by Oceania does not include evidence of adequate evaluation of wound progress and status. Such evaluation occurred only once the district nurses began weekly visits to assess the wound from 9 Month6. RN Parmee considered this to be a significant departure. I agree that evidence of evaluation of the pressure wounds is lacking. I accept RN Parmee's advice that Mr A's wound infection was not detected in a timely manner and was preventable.

96. Furthermore, although Mr A's heel wounds were notified to HealthCERT on 5 Month3, shortly after they were first observed, the buttock wound was not reported to HealthCERT until 16 Month7, over a month after the swab result confirmed that the wound was MRSA positive. The notification stated that the wound was unstageable, that it was first identified on 11 Month5, and that a wound specialist nurse had assessed it on 26 Month6.

97. RN Parmee commented that the notification to HealthCERT was both inaccurate and unacceptably late, and that the inaccuracies are a serious discrepancy. She stated that while HealthCERT notification is not required until a wound is at stage 3, it is difficult to ascertain from the documentation when this occurred because of the gap in documentation from when redness was noted until the wound was infected.

98. I agree. I am concerned at the inaccuracy of detail on the notification to HealthCERT. In particular, the date the wound was reported as first identified is incorrect, and the wound had in fact not been assessed by a wound specialist nurse. I note that RN Parmee considered that the ongoing review by district nurses (with wound specialist nurse advice) was appropriate, but I am concerned that this arrangement was not captured accurately in the HealthCERT notification. I am also critical of the delay in notifying HealthCERT of the buttock wound.

Bladder infection

99. Mr A did not have fluid balance monitoring commenced when he was admitted to the rest home. Mr B told HDC that Mrs A had taken very seriously the instructions from the spinal unit that Mr A was to consume 2–3L of water per day, but that it was a struggle to get Oceania to take this aspect of Mr A's care seriously.

100. During a routine catheter change on 17 Month4, RN D found that Mr A's catheter was partially blocked and that he had pus in his urine. A UTI was confirmed, and Dr F commenced Mr A on antibiotics and recommended that a fluid balance chart be started. This was filled in by multiple different staff. The daily charts are often incomplete, and the daily totals of fluid input and output were not recorded regularly or entered into the progress notes regularly. Mr A was admitted to hospital for treatment of his infection on 24 Month4.

101. RN Parmee advised:

> "[Mr A] had a long term supra pubic catheter in place. This is immediately a potential source of infection. Along with [Mr A's] lack of sensation and therefore ability to identify pain it was important that his fluid intake and output be monitored closely.
>
> …
>
> [G]iven [Mr A's] specific needs, related to his spinal injury … fluid balance should have been recorded … from his initial admission and on the advice of his wife. While I accept that there are protocols related to the monitoring of fluid balance, I believe that [Mr A's] case fell outside these bounds."

102. The fluid balance forms were often incomplete, the input total was not always provided, and the fluid balance was seldom entered into the progress notes. As RN Parmee observed, the lack of fluid balance monitoring and inadequate fluid intake may have contributed to the late detection and severity of Mr A's urinary tract infection.

103. I accept RN Parmee's advice that Mr A's bladder infection was not detected in a timely manner and was preventable. I am critical that the rest home did not initiate fluid balance recording from the outset, given that Mr A had a long-term suprapubic catheter, which was a potential source of infection, or ensure that such recording was completed adequately once it was initiated. This was an important element of care highlighted by Mrs A, and again shows a failure by staff to act on input from Mr A's family.

Conclusion

104. Overall there were serious issues with the care planning and delivery of care to Mr A at the rest home, and unfortunately these echoed the issues that had been identified in the July 2017 audit against the Health and Disability Services Standards. In my view, Oceania should have been alert to the problematic themes arising from the audit, at the time of Mr A's admission in Month2. The rest home accepted Mr A into its care and, as such, it then assumed responsibility for meeting his needs and keeping him safe. Without the appropriate support and interventions, Mr A's health had the potential to deteriorate rapidly, and he was at risk of developing complications.

105. In response to my provisional opinion, Oceania submitted that at the time of RN B's employment, her job description clearly stated that she would be responsible for overseeing care delivery, would be responsible for ensuring that training of staff was up to date and relevant to the cares required by the residents, and that assessments, including interRAI, care plans, and evaluations were up to date. While I acknowledge Oceania's submission, in my opinion there were multiple issues with the care planning and delivery of care to Mr A. My expert advisor, RN Rachel Parmee, stated:

> "[RN B] was not solely responsible for the monitoring of residents and supervision of staff. Responsibilities within the Clinical Manager role were shared with the Business and Care Manager while she was performing other duties within the role. She also relied upon the information provided at verbal and written handovers from the other RNs and the information contained in incident forms."

106. I accept RN Parmee's advice, and I am comfortable that the deficiencies in Mr A's care are attributable to Oceania as the service provider, and employer of the numerous staff involved in Mr A's care at the rest home. In my view, Oceania failed to provide Mr A with an appropriate standard of care for the following reasons:

a) The assessment of, and care planning for, Mr A was inadequate, in that there was a lack of initial consultation with Mrs A, an interRAI assessment was not completed in a timely manner, and there was a lack of documented assessment of Mr A's pressure-injury risk or plans to mitigate that risk.

b) Documentation and evaluation of wound progress was lacking, and the notification to HealthCERT of Mr A's buttock wound was inaccurate and delayed.

c) Fluid balance monitoring was not completed from the outset, despite Mr A having a suprapubic catheter in place, which put him at risk for developing an infection.

d) There was a failure by multiple staff to follow Oceania policies and procedures. In particular: an unapproved restraint was used in contravention to Oceania policy and without suitable provision of pressure relief; Mr A's long-term person-centred care plan was not completed within the specified timeframe; and fluid balance documentation charts were not completed adequately.

107. I consider that these issues contributed to the failure to put in place effective actions to prevent and manage Mr A's serious pressure injuries and infections. Accordingly, I find that Oceania Care Company Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[20]

Opinion: RN C — adverse comment

108. RN C was the Restraint Coordinator at the rest home. On 15 Month2, RN C and Mrs A signed a restraint consent form that provided for Mr A to be placed in a recliner chair, to prevent him trying to leave the rest home in his wheelchair. On 18 Month2, GP Dr F co-signed the form. The form stipulated that Mr A required hourly monitoring when in the recliner chair.

109. Oceania had only four approved forms of restraint; these did not include using a recliner chair as a restraint. RN C told HDC that as Mr A was unable to move freely from the recliner chair himself (owing to his paraplegia), they "considered it to be a restraint and documented it as such to ensure his safety and that regular monitoring checks were in place. (Even though this was not an approved Oceania restraint.)"

110. Oceania noted that no input or advice was sought from the Oceania Healthcare Clinical and Quality team regarding the use of a non-approved restraint. However, Oceania's "Restraint Minimisation and Safe Practice Handbook and Policies" did not provide guidance on what to do in circumstances where a non-approved restraint was being considered.

111. My expert advisor, RN Rachel Parmee, commented that "given the guidelines around pressure relief for people with spinal cord injuries, hourly pressure relief is not frequent enough". She stated: "It is also not possible to ascertain from the information provided if this monitoring did, in fact, include pressure relief." RN Parmee advised that the form of restraint used was inappropriate, as it contributed to the development of Mr A's pressure injuries.

[20] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

112. I accept RN Parmee's advice. I acknowledge that RN C had input from Mrs A and Dr F regarding the recliner chair restraint for Mr A. However, I consider that as the Restraint Coordinator at the rest home, RN C was responsible for ensuring that the form of restraint was appropriate for Mr A's specific needs. Mr A had paraplegia, which meant that he required more regular pressure relief than most residents, and being confined to a recliner chair was unlikely to allow Mr A to reposition himself; he would have been reliant on staff to do this. I am critical that RN C signed off a form of restraint that was unsuitable for Mr A, and that it was not an approved restraint in line with the Oceania policy. I am also concerned that she did not provide guidance for pressure relief while the restraint was in use. While I note that Oceania considered that RN C should have sought guidance from the Oceania Healthcare Clinical and Quality team, I consider that the policy did not provide adequate guidance on what to do when faced with the circumstance of considering the use of an unapproved form of restraint.

Recommendations

113. I recommend that Oceania Care Company Limited:

a) Ensure that all the rest home nursing staff have completed training on resident care planning by the end of March 2021. This training should reference the importance of utilising all sources of information (including family) in the assessment process, and conducting ongoing review of the effectiveness of the plan of care.

b) Have an external advisor provide training to nursing staff at the rest home on pressure-area risk assessment, and management of pressure areas, including clear documentation of evaluation.

c) Provide evidence that all nursing staff at the rest home are aware of the statutory obligations in relation to essential notification reporting (particularly for pressure areas).

d) Conduct an audit of monitoring forms (eg, fluid balance records) used for 15 residents in November 2020, to ensure that these forms are being used appropriately and that results are followed up. If the results of the audit show that the forms are not being used appropriately, provide internal training to all nursing and caregiving staff at the rest home on the importance of completing monitoring forms accurately.

e) Conduct an audit of 15 recent admissions to the rest home to determine whether long-term person-centred care plans and interRAI assessments are being completed in the required timeframes.

f) Review its restraint policy documents to include guidance on pressure-relief management while restraints are in use.

g) Provide HDC with feedback on the implementation of recommendations a) to f), within three months of the date of this report.

h) Provide a written apology to Mr A's wife and son for the failings in care delivery identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to the family.

114. I recommend that RN C provide a written apology to Mr A's wife, Mrs A, and his son, Mr B. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to the family.

Follow-up actions

115. Oceania Care Company Limited will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

116. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Oceania Care Company Limited, will be sent to the district health board, HealthCERT, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

117. Following negotiations with the provider, the Director of Proceedings decided to file proceedings in the Human Rights Review Tribunal by consent.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rachel Parmee:

"Thank you for the request that I provide expert advice in relation to the care provided by [the rest home] (Oceania Healthcare) to [Mr A] from 9 [Month2]–31 [Month8].

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.

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.

Background

[Mr B] has raised concerns about the care his father ([Mr A]) received from [the rest home] (Oceania Healthcare).

[Mr B] believes that [the rest home] failed to adequately manage his father's pressure sore injuries and failed to make timely notifications of his pressure sores to HealthCERT. The complainant has also raised further concerns about the management of his father's bladder infection and chest infection.

Oceania Healthcare responded to [Mr B's] complaint in a letter dated 3 [Month10].

They advise that [rest home] staff did not meet Oceania Healthcare's standards or the family's expectation. Oceania Healthcare has conducted an internal investigation and have accepted a number of failings in their care.

The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr A] by Oceania Healthcare was reasonable in the circumstances and why with particular comment on:

1. Assessment and management of [Mr A's] pressure injuries.
2. The adequacy of the clinical documentation and reporting regarding [Mr A's] pressure injuries
3. Assessment and management of [Mr A's] infections.
4. Communication with [Mr A's] family regarding his condition.
5. The timeliness of conducting an interRai assessment of [Mr A].
6. Whether the use of restraint on [Mr A] was appropriate.
7. Whether it was appropriate to have a district nurse attend [Mr A] instead of a Wound Nurse Specialist.
8. Any other matters in this case 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, how significant a departure do I consider this to be?

c) How would it be viewed by peers?

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

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

1. Letter of complaint from [Mr A's] son [Mr B] dated 31 [Month8].
2. Further information submitted by [Mr B] on 22 [Month9].
3. Oceania Healthcare's responses dated 29 [Month9] and 3 [Month10].
4. Clinical records and relevant policies from Oceania Healthcare covering the period [of admission].
5. [Mr B's] comments on Oceania Healthcare's response.

Review of Documents and Comments

1) Assessment and management of [Mr A's] pressure injuries.

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

Prior to any discussion around assessment and management of pressure injuries it is necessary to discuss prevention of the occurrence of pressure injuries in the first place. This requires a comprehensive assessment of the patient in order to identify risk factors for pressure injuries. In [Mr A's] case three major risk factors existed:

- A 26 year history of paraplegia
- Frontal lobe dementia
- Advanced age

Kruger, Pires, Ngann, Sterling and Rubayi (2013) state that patients with SCI, (spinal cord injury) its chronic comorbidities and lack of protective sensory perception, are a particularly vulnerable population for developing ulcers and are at high risk for recurrent ulcers.

[Mr A's] wife and son [Mr B] both state that [Mr A] had not suffered any pressure injuries during the 26 years that he, and later his wife, managed pressure injury prevention related to his paraplegia.

In order to prevent pressure injuries it was vital that an assessment was made on admission, with input from [Mrs A] and the spinal injury experts who had been managing [Mr A's] care. This should then have informed the care plan for [Mr A]. It is clear from the documentation provided that this did not happen.

Following his admission to [the rest home] [Mr A] left the facility on two occasions to return to his home. In order to prevent this happening it was decided to remove his self-propelling wheelchair and place him in an armchair. [Mr B] (12th [Month10]) states that when this occurred [Mrs A] made it clear that [Mr A] would require regular pressure relief. The need for regular pressure relief is important for all patients who are not able to change position independently. It is even more important for a patient with paraplegia as they do not experience the triggers to change position of pain or discomfort due to the lack of sensation from the waist down.

Kruger et al (2013) state that tissue injury is related to both extrinsic and intrinsic factors. In [Mr A's] case extrinsic factors included immobility related to his paraplegia, compounded by restraint in an armchair with increasing ongoing pressure to his heels and buttocks. Intrinsic factors included altered level of cognition related to his dementia, increased age and sensory loss. Recommendations for high risk patients include 2 hourly turns while in bed and pressure relief during prolonged sitting of 10 seconds every 10 minutes. (Kruger et al, 2013)

It appears that [Mr A's] pressure injuries occurred within the first weeks of his admission to [the rest home] while he was in respite care. There is no evidence in the progress notes that pressure relieving measures were in place during this period. Two hourly turns and pressure relieving measures were documented after the appearance of pressure injuries.

[Mr A] suffered frontal lobe dementia. As a consequence he lacked insight into his physical care needs such as changing position. It is also noted that on occasions he was aggressive towards staff when they were providing cares including pressure relieving turns.

Accepted practice would be that on admission to a facility, a comprehensive assessment takes place to identify problems, appropriate interventions and evaluations. In all cases there should be input from the patient and family members. In this case, given that [Mr A] had a long term condition that he and his wife had managed for 26 years, it was vital that [Mrs A] provided information on the prevention of pressure injuries and that this be included in the assessment and care plan.

A full careplan was dated 24th [Month5]. The DHB requirement is that this is completed within 3 weeks of admission. (Age-Related Residential Care Services Agreement: 2012) At no point is there a stipulation that areas at risk for pressure injuries (e.g. heels and buttocks) be checked for signs of pressure. At no point is there a stipulation that during the 30 minute restraint checks [Mr A] be assisted to change position. As [Mr A] had both a colostomy and urinary catheter in place there was no incidental opportunity to check his buttocks for signs of pressure. It is also of interest that although the use of a Roho cushion is noted in the careplan, this is crossed out. The Roho cushion was recommended by a physiotherapist on 24 [Month4]. In his letter of [2018] [Mr B] says that the Roho cushion was being used. There is a discrepancy between this recommendation and information on the careplan.

Using the adage that if it is not documented it did not happen it appears that there was no timely assessment or planning which included measures to prevent and monitor for pressure injuries.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

There is a significant departure from accepted practice in that an initial assessment and careplan for [Mr A] were not completed in a timely manner. There was no consultation with [Mr A's] wife or relevant health professionals (such as the staff of the Spinal Injuries Unit) to ascertain particular needs and cares related to [Mr A's] paraplegia. By the time this occurred [Mr A] already had pressure injuries.

c. How would it be viewed by peers?

My peers in education and practice would agree.

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

The facility needs to follow the assessment and care planning guidelines using the interRAI assessment appropriately. Information for assessment should be gathered from all interested parties including family and other institutions providing care to the

patient. Careplan instructions should be followed and recorded in progress notes and reviewed as patient status changes.

2) The adequacy of the clinical documentation and reporting regarding [Mr A's] pressure injuries

Documentation provided around [Mr A's] pressure injuries includes pressure injury careplan, pressure injury assessment and monitoring forms, photographs and daily progress notes. Documentation provided, relating to reporting of pressure injuries, consists of the two reports to HealthCERT.

The short term care plan dated 29 [Month2] for pressure ulcers on both heels, states that the pressure injury was initially grade 2 and changed to unstageable on 23 [Month3].

There is a short term careplan, dated 14 [Month6] for wound infection (MRSA) on the buttocks, and a further short term care plan dated 13 [Month7] for the same wound.

The timeline provided by [Ms G] ([General Manager]) indicates that the two heel pressure areas were identified on 29 [Month2], which coincides with the initial careplan. The progress notes for that day state that the heels were bandaged as no heel protectors were available. This statement reinforces the lack of preventative care provided to [Mr A].

The prepopulated care plan lists Braden score reassessment in its interventions. There is no evidence in the notes of a Braden score being completed at any time including on admission. The facility may have chosen not to use this tool. If this is the case the pre-populated careplan needs to be updated to accurately reflect care provided. However it is important to have a regular assessment and score of [Mr A's] pressure area risk, such as would be provided by a Braden score.

The pressure injury monitoring and assessment forms are completed with each dressing change. These forms include measurement of the wound and provide descriptors of exudate and peri-wound area, ticking dressing done with no evaluation of the wound. Photographs of the heel and buttock wounds are included taken at roughly one monthly intervals between 08 [Month3] and 08 [Month5]. This documentation is adequate and regular. However, there is little evidence of evaluation of the progress of the wounds. This only occurs once the District Nurse begins weekly visits commencing 15 [Month6] to assess the wound and change dressing instructions following assessment.

In regard to the reporting of the buttock wounds to HealthCERT, both [Ms G] and [Ms H] (Clinical and Quality Manager) note that there was an unexplained delay in the reporting process. They also accept [Mr B's] contention that the pressure injuries to [Mr A's] heels occurred during his time at [the rest home] in respite care prior to his full admission.

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

Clinical documentation around wounds should be accurate and include ongoing evaluation. Ongoing evaluation and review did not appear to occur until the District Nurse conducted weekly reviews. Accepted practice would be that RNs completing dressings would also provide evaluation along with description of the wounds and note this in progress notes. HealthCERT notifications should occur in a timely manner in order for the required investigation to commence. In the case of the heel injuries notification was made within a week of the injury being observed. However in the case of the buttock wound there is a gap in documentation between 05 [Month4] when redness was noted through to 06 [Month6] when the wound was infected and a swab taken. While HealthCERT notification is not required until a wound is at stage 3 it is difficult to ascertain from documentation when this occurred. There is a gap of 20 days between the swab being taken and HealthCERT notification. This is beyond an acceptable timeframe.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

This is a significant departure. While documentation of wound progress is present it does not show any evaluation. Purpose of the documentation is to show what was done but also evidence of evaluation. Notification to HealthCERT was both inaccurate and unacceptably late.

c. How would it be viewed by peers?

Peers would expect the nursing process to be followed which includes evaluation.

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

Education of the registered nurse staff on the importance of evaluation of wounds and the need to engage the expertise of the Wound Care specialist when slow to heal wounds are present. Education of registered nurses around purpose and process of HealthCERT notifications is also needed.

3) Assessment and management of [Mr A's] infections.

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

[Mr A] experienced both bladder and wound infections during his time at [the rest home]. In both cases the infections were not detected in a timely manner and were preventable. On admission to [the rest home], [Mrs A] advised staff that, on the advice of [the spinal unit] that his daily fluid intake needed to be between 2 to 3 litres. Given [Mr A's] decreased cognitive ability this would have required regular encouragement to drink and recording of fluid intake. Accepted practice would have been commencement of monitoring and recording on admission.

[Mr A] had a long term supra pubic catheter in place. This is immediately a potential source of infection. Along with [Mr A's] lack of sensation and therefore ability to

identify pain it was important that his fluid intake and output be monitored closely. Fluid balance monitoring was not commenced until 17 [Month4] following a routine change of catheter when it was noted that 'catheter was partially blocked and very offensive pus in his urine'. A short term careplan was commenced on 17 [Month4] for a urinary tract infection. [Mr A] was seen by the GP and antibiotic charted. There is no record of a short term careplan being commenced or details of visit by the GP in the progress notes. The care provided on this occasion was accepted practice. However the lack of documentation in the progress notes and lack of fluid balance monitoring prior to the infection occurring is of concern. [Mr A] was admitted to the public hospital on 24 [Month4] for treatment of urosepsis as a consequence of his urinary tract infection not resolving.

On review of the fluid balance forms provided there were several occasions where the form was incomplete and many occasions when the input total was not provided and very few occasions where the fluid balance was entered into the progress notes. In his comments (12th July) [Mr B] states that his mother had reiterated the instructions from [the spinal unit] that [Mr A] needed to maintain a daily intake of 2 to 3 litres of water. The fluid balance charts indicate that this did not occur on a daily basis. Adequate hydration is important in maintaining skin integrity and prevention of urinary infections, particularly where, as in [Mr A's] case there was a long term urinary catheter in place.

[Mr A] also experienced an infected wound on his buttock. As discussed above there was no documentation of the progress of this wound from redness to an unstageable pressure injury within 2 months. The buttock wound was swabbed and found to be infected with MRSA during [Mr A's] hospitalisation. It is of concern that the wound was not found and swabbed during regular checks by the staff of [the rest home]. The assumption is that regular pressure area monitoring was not taking place.

Wound and bladder infections appear to have been discovered and acted on late. Regular monitoring of fluid balance and pressure areas were undertaken after infections appeared. Again there is no evidence of planned preventive care or adherence to the information provided by [Mr A's] family.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

There is a significant departure from the accepted standard of care. Short term care plans and appropriate treatment of infections are evident. However there is no evidence of proactive planning of care in relation to [Mr A's] specific needs. It is also a significant departure that the buttock wound was found by [public hospital] staff indicating [rest home] staff were not undertaking regular monitoring. The lack of fluid balance monitoring and inadequate fluid intake also contributed to the late detection and severity of [Mr A's] urinary tract infection.

c. How would it be viewed by peers?

My peers in education and practice would agree that there is a significant departure from the accepted level of care leading to two preventable infections.

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

My recommendation is that there be congruency between progress notes and significant events. The purpose of progress notes is to include documentation of changes in status and provide information between staff. I would also recommend preventative measures such as monitoring and accurate recording of fluid balance be in place. Both infections were predictable and preventable.

4) Communication with [Mr A's] family regarding his condition.

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

Accepted practice in relation to communication with family would include consultation in all stages of assessment and care planning and notification of any significant events such as falls. I have discussed above the lack of consultation with [Mr A's] family in the initial assessment and care planning and the consequences of this lack of consultation. The provided list of communications with family begins on 18 [Month5]. There is no record included of communications prior to this date. There is no evidence of discussion of care planning until 08 [Month6] when I assume [Mr B] initiated the discussion.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

There is a significant departure from the expected standard of care. The lack of consultation with [Mr A's] family around his specific physical care needs, I believe, contributed to the development of his pressure injuries and infections. This lack of communication is not congruent with the concept of person-centred care.

c. How would it be viewed by peers?

I believe my peers would agree with my view.

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

My recommendation is that the policies and procedures around communication with family particularly in relation to assessment and care planning be followed.

5) The timeliness of conducting an interRAI assessment of [Mr A].

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

An interRAI assessment should be completed prior to admission to hospital level care and within 6 weeks of admission. In this case the first assessment following admission took place on 11 [Month5], 13 weeks after [Mr A's] admission to [the rest home].

There is no evidence of [Mrs A] being included in this assessment. Any reference to her is the same as the information in the Needs Assessor assessment of [Month1].

The Initial Person centred careplan dated 09 [Month2] is intended to be replaced by a full careplan within 3 weeks of admission and be informed by the interRai assessment. It is of interest to note that updates were made to the initial careplan after consultation with [Mr A's wife] on 11 [Month3]. These updates include strict fluid intake, heel protectors, 2 hourly turns, decreased feeling and circulation in lower legs.

In her submission [Ms G] states that an interRAI assessment should have been completed for reassessment of level of care. I am assuming she means assessment for care in a hospital level dementia unit. I accept that [Mr A's] behaviour was an issue and there were times when his behaviour prohibited nurses from performing pressure area care. I note there was input from specialists in mental health. Reassessment was also needed following the development of [Mr A's] pressure injuries and infections.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

There has been a significant departure from accepted practice in that neither the initial interRAI assessment nor a reassessment were completed in a timely manner. This not only meant a compromise in the quality of care [Mr A] received but also contravention of District Health Board requirements for interRAI assessments.

c. How would it be viewed by peers?

My peers in education and practice would view this as a significant departure.

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

I recommend education of Registered Nurses around the purpose and importance of accurate and timely interRAI assessments.

6) Whether the use of restraint on [Mr A] was appropriate.

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

There is a distinction between enablers and restraint. Restraint is defined as limiting the actions of a consumer in circumstances in which the consumer is at risk of injury or of injuring another person. Enablers are equipment, voluntarily used by a consumer, following appropriate assessment that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety (RMSP NZS 8134:2008).

In the case of [Mr A] it can be assumed that the bedrails would be described as enablers while confinement to an armchair was restraint.

The restraint assessment, authorisation, plan and consent form related to the use of a recliner chair was signed 15 [Month2] stipulating one hour monitoring. Consent for

bedrails was completed on 17 [Month4] following a fall out of bed. Evaluation of the bedrail enablers was documented on 30 [Month4]. The use of the recliner chair was evaluated on 21 [Month2] identifying pressure areas as a potential risk of the restraint. I was also unable to locate any daily restraint monitoring records — a requirement during the use of restraint.

As stated earlier [Mrs A] was concerned about the lack of pressure relief taking place during the time [Mr A] was confined to the recliner chair and the subsequent development of pressure injuries. Given the guidelines around pressure relief for people with spinal cord injuries, hourly pressure relief is not frequent enough. It is also not possible to ascertain from the information provided if this monitoring did, in fact, include pressure relief. For this reason the form of restraint was considered inappropriate and its use caused harm to [Mr A]. In her letter (dated 29 [Month6]) [Ms H] states that the use of the recliner chair was not a method of restraint approved by Oceania.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

This is a significant departure from accepted practice as the form of restraint used was inappropriate in this case as its use contributed to the development of pressure injuries and was not an approved form of restraint within Oceania policy. Monitoring was neither documented nor appropriate given [Mr A's] physical needs.

c. How would it be viewed by peers?

My peers would agree with this finding.

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

All staff need to be educated about the legal requirements of restraint being appropriate, evaluated and monitored. As [Ms H] states education is required around Oceania restraint policies.

7) Whether it was appropriate to have a district nurse attend [Mr A] instead of a Wound Nurse Specialist.

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

[Ms H] notes that the Wound Care Nurse was consulted by the District Nurse on 13 [Month3] and again on 09 [Month6]. The HealthCERT notification and subsequent Serious or Sentinel Event Investigation Form both state that a wound nurse specialist had assessed the wound. [Ms G] states the registered nurses should have been more proactive in ensuring that the wounds were assessed in person by the DHB Wound Nurse Specialist.

Accepted practice would be that the requirements of the HealthCERT notification were met and accurately recorded. In this case the wounds should have been assessed in person by the Wound Care Nurse. I am unable to ascertain the experience or

qualifications of the District Nurse managing [Mr A's] dressings. However, I assume that by virtue of the Wound Care Nurse being willing to provide telephone advice and the quality of documentation and decisions made by the District Nurse, she was capable of providing the required level of care to [Mr A].

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

I consider this to be a significant departure from accepted practice. The information provided on the HealthCERT notification was inaccurate, and therefore a serious discrepancy. The requirement of assessment by a wound care specialist is to ensure that a wound that is Grade 3 or above is treated appropriately. This did not occur for [Mr A].

I agree with [Ms G] that this should have been pursued by the registered nurses. However, I believe that the ongoing assessment of the wounds by a District Nurse was appropriate and acknowledge that advice was sought from the Wound Care Specialist.

c. How would it be viewed by peers?

My peers would, I believe agree with this finding.

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

Further education is required around the importance of accurate reporting and the use of appropriate resource people as stipulated and required.

I have no further matters that I wish to raise in this case.

Rachel Parmee

References

Age-Related Residential Care Services Agreement: Provision of Aged Related Residential Care (2012) sections D16.2 to D16.4 http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/age-relatedresidential-care-services-agreement

Kruger, E. A., Pires, M., Ngann, Y., Sterling, M., & Rubayi, S. (2013). Comprehensive management of pressure ulcers in spinal cord injury: Current concepts and future trends. The Journal of Spinal Cord Medicine, 36(6), 572–585.

NZS 8134: (2008) Health and Disability Services (Restraint Minimisation and Safe Practice) Standards"

The following further advice was received from RN Parmee:

"Thank you for the opportunity to review further information in relation to case 18HDC01049 for which I provided a report dated 11/12/2018.

I have been provided the following information to review:

1. My December 2018 report
2. Oceania's response to HDC letter dated 10 July 2019 asking for comment on issues raised in my report.
3. Oceania's appendices to its response including:
   a. Appendix One, Oceania's policies
   b. Appendix Two, Oceania's job descriptions
   c. Appendix Three, Minutes of Oceania's meeting
   d. Appendix Four, Oceania's staff education records
4. Oceania's staff statements.
5. Oceania's Wound Care Plans and Pressure Injury Care Plans for [Mr A], dated:
   i. 7 [Month3]
   ii. 13 [Month5]
   iii. 8 [Month6].
6. The complainant's response dated 21 June 2019
7. [The DHB's] response dated 19 July 2019.

Background

The complainant, [Mr B] has raised concerns about the care his late father, [Mr A], received from [the rest home] (Oceania Healthcare).

[Mr B] believes that [the rest home] failed to adequately manage his father's pressure sore injuries and failed to make timely notifications of his pressure sores to HealthCERT. The complainant has also raised further concerns about the management of his father's bladder infections and chest infection.

Oceania Healthcare responded to [Mr B's] complaint in a letter dated 3 [Month10]. It advised that [rest home] staff did not meet Oceania Healthcare's standards or the family's expectation. Oceania Healthcare has conducted an internal investigation and accepted a number of failings in their care.

Expert Advice Requested

I am asked to review the documentation (listed above) and comment on

1. Whether the information in these responses causes me to change my original advice in any way and why/why not.

2. Where I have identified departures from the accepted standard of care, to advise whether the departure is a systems or individual issue. As part of this discussion I am asked to comment on Clinical Manager, [RN B's] care and any other individual nurse involved where I consider it appropriate.
3. Whether the policies and procedures provided by Oceania meet accepted standards.
4. Whether training provided to staff is adequate and appropriate.
5. Any other matters in this case that I consider warrant comment.

1. Whether the information in these responses causes me to change my original advice in any way and why/why not.

The information in these responses does not cause me to change my original advice for the following reasons:

a. Assessment and management of [Mr A's] pressure injuries.

In my original report I stated that:

Accepted practice would be that on admission to a facility a comprehensive assessment takes place to identify problems, appropriate interventions and evaluations. In all cases there should be input from the patient and family members. In this case, given that [Mr A] had a long-term condition that he and his wife had managed for 26 years, it was vital that [Mrs A] provided information on the prevention of pressure injuries and that this be included in the assessment and care plan.

An interRAI assessment should be completed prior to admission to hospital level care and within 6 weeks of admission. In this case the first assessment following admission took place on 11 [Month5], 13 weeks after [Mr A's] admission to [the rest home]. There is no evidence of [Mrs A] being included in this assessment. Any reference to her is the same as the information in the Needs Assessor assessment of [Month1].

I still maintain that there was a lack of any comprehensive patient-centred initial assessment which would have highlighted the need to prevent pressure injuries. Because of this, measures to prevent and monitor for pressure injuries were not in place. The failure to include [Mrs A's] input into the assessment was significant and was not mentioned in the responses.

b. The adequacy of the clinical documentation and reporting regarding [Mr A's] pressure injuries.

In her letter [Ms H] acknowledges that there was a delay in notification of the pressure injuries and that there was no follow up by clinical staff after receipt of a letter from Older Peoples' Mental Health service stating the sacral wound was deep and offensive. I still maintain that this delay was unacceptable and that the documentation provided does not include adequate evaluation of wound progress and status.

c. Assessment and management of [Mr A's] infections

As I stated in my initial advice [Mr A's] buttock wound (which was infected with MRSA) were both discovered and acted on later than an acceptable timeframe. This indicates lack of monitoring and preventative measures. The maintenance of a daily input of 2 to 3 litres of water a day was needed to prevent bladder infections. [Ms G] notes that fluid balance recording was commenced after a doctor consult prior to hospital admission for urosepsis. She also notes the need for 2 to 3 litres of fluid following a visit to [the spinal unit] outreach. She acknowledges gaps in the recording of information on the Fluid Balance charts which is unacceptable.

The fluid intake requirement had been stated by [Mrs A] on admission and apparently ignored in terms of documentation and inclusion in initial assessment data.

d. Communication with [Mr A's] family regarding his condition

[Ms G] states that a lack of dates prevents her from commenting on communication with [Mr A's] family in particular around the progress of his pressure injuries. As stated above there was inadequate documented evidence of consultation with [Mr A's] family around his particular care needs.

e. The timeliness of conducting an interRAI assessment of [Mr A]

Both [Ms H] and [Ms G] acknowledge that an interRAI assessment should have been completed within the first month of [Mr A's] placement in the facility. They state that this would have indicated the inappropriateness of his placement at [the rest home]. I would add to this that interRAI assessment was also necessary to properly assess [Mr A's] care needs while at [the rest home]. In the absence of such an assessment the facility did not provide appropriate care in terms of pressure area management, infection prevention and appropriate use of restraint.

f. Whether the use of restraint on [Mr A] was appropriate

Both [Ms H] and [Ms G] acknowledge that restraint used on [Mr A] was neither in his best interest or approved by Oceania. The organisation's restraint policy was not followed.

g. Whether it was appropriate to have a district nurse attend [Mr A] instead of a Wound Nurse Specialist

[Ms G] states that the Registered staff should have been more proactive in ensuring that the wounds were assessed in person by the DHB Wound Nurse Specialist. I note that a current resident is under the direct care of the wound nurse specialist. While this indicates that staff are now more proactive in ensuring that a wound care specialist is used it does not alter my initial advice that the same should have happened for [Mr A].

2. Where I have identified departures from the accepted standard of care, to advise whether the departure is a systems or individual issue. As part of this discussion I

am asked to comment on Clinical Manager, [RN B's] care and any other individual nurse involved where I consider it appropriate.

It appears from the responses provided by [Ms H] and [Ms G] that they attribute responsibility for the late notification to HealthCERT to have been the responsibility of the [RN B] as Clinical Manager. I agree with this.

In terms of documentation, including initial and ongoing assessment, care-planning, progress notes and maintenance of records such as fluid balance and wound care management, the responsibility lies with the registered nurses under the supervision of [RN B]. I would expect this supervision to include regular review of all documentation. In the case of [Mr A] with his multiple needs, both physically and behaviourally, I would expect a clinical manager to be providing daily supervision of his care including hands on assessment of his status. It would have been her responsibility to have initiated an interRAI assessment as soon as possible after [Mr A's] admission given the concerns about the appropriateness of his placement and most certainly within the required 6-week time frame.

The statement provided by [RN B] confirms her actions and timeframes as documented in the information provided for my initial report. I therefore conclude that she did not provide appropriate supervision of the care provided to [Mr A] in terms of ensuring that care was planned proactively rather than reactively and did not ensure that information provided by [Mr A's] family was acted upon in a timely manner.

3. Whether the policies and procedures provided by Oceania meet accepted standards

The policies and procedures provided by Oceania do meet accepted standards. My concern is that they need to be followed to the standard required and that all staff, particularly the Clinical Manager and registered nurses are familiar with their implementation and understand the rationale behind them.

4. Whether training provided to staff is adequate and appropriate

In the wake of [the family's] complaint staff education sessions have been arranged and delivered — skincare, pressure injury care and restraint. This is appropriate.

I would like also to see further education on the process of assessment utilising all sources of information (including family), planning care based on this assessment and ongoing review of the effectiveness of the plan of care.

I believe the inconsistencies in timing of assessments, reports and interventions and quality of documentation contributed to the issues raised around the care provided to [Mr A]."

The following further advice was received from RN Parmee:

"Thank you for the opportunity to provide a further response in this case.

I am asked to review [RN B's] response (dated 21 November 2019) and advise HDC whether the information in her response causes me to change my earlier advice (both in my December 2018 report and September 2019 report) in any way and why/why not.

I have been provided the following documents which were used for my previous advice:

1. Letter of complaint from [Mr A's] son, [Mr B], dated 31 [Month8].
2. Further information submitted by [Mr B] on 22 [Month9].
3. Oceania Healthcare's responses dated 29 [Month9] and 3 [Month10].
4. Clinical records and relevant policies from Oceania Healthcare covering the period from [Month2]–[Month8].
5. [Mr B's] comments on Oceania Healthcare's response.
6. My December 2018 report.
7. Oceania's response to HDC letter dated 10 July 2019 asking for comment on issues raised in my report.
8. Oceania's appendices to its response including:
    a. Appendix One, Oceania's policies
    b. Appendix Two, Oceania's job descriptions
    c. Appendix Three, Minutes of Oceania's meeting
    d. Appendix Four, Oceania's staff education records
9. Oceania's staff statements.
10. Oceania's Wound Care Plans and Pressure Injury Care Plans for [Mr A], dated:
    i. 7 [Month3]
    ii. 13 [Month5]
    iii. 8 [Month6].
11. The complainant's response dated 21 June 2019.
12. [The DHB's] response dated 19 July 2019.

Additional documents referred to in this report are:

1. My September expert advice report
2. [RN B's] response dated 21 November 2019

Background

The complainant, [Mr B] has raised concerns about the care his late father, [Mr A], received from [the rest home] (Oceania Healthcare).

[Mr B] believes that [the rest home] failed to adequately manage his father's pressure sore injuries and failed to make timely notifications of his pressure sores to HealthCERT. The complainant has also raised further concerns about the management of his father's bladder infections and chest infection.

Oceania Healthcare responded to [Mr B's] complaint in a letter dated 3 [Month10]. It advised that [rest home] staff did not meet Oceania Healthcare's standards or the family's expectation. Oceania Healthcare has conducted an internal investigation and accepted a number of failings in their care.

Relevant previous advice

For my September 23rd, 2019 report I was asked:

Where I have identified departures from the accepted standard of care, to advise whether the departure is a systems or individual issue. As part of this discussion I am asked to comment on Clinical Manager, [RN B's] care and any other individual nurse involved where I consider it appropriate.

My response was based on the information provided by [Ms H] and [Ms G] and the Clinical Manager job description provided and was as follows:

It appears from the responses provided by [Ms H] and [Ms G] that they attribute responsibility for the late notification to HealthCERT to have been the responsibility of [RN B] as Clinical Manager. I agree with this.

In terms of documentation, including initial and ongoing assessment, care-planning, progress notes and maintenance of records such as fluid balance and wound care management, the responsibility lies with the registered nurses under the supervision of [RN B]. I would expect this supervision to include regular review of all documentation. In the case of [Mr A] with his multiple needs, both physically and behaviourally, I would expect a clinical manager to be providing daily supervision of his care including hands on assessment of his status. It would have been her responsibility to have initiated an interRAI assessment as soon as possible after [Mr A's] admission given the concerns about the appropriateness of his placement and most certainly within the required 6-week time frame.

The statement provided by [RN B] confirms her actions and timeframes as documented in the information provided for my initial report. I therefore conclude that she did not provide appropriate supervision of the care provided to [Mr A] in terms of ensuring that care was planned proactively rather than reactively and did not ensure that information provided by [Mr A's] family was acted upon in a timely manner.

I note that [RN B] is not subject to an individual investigation at this time.

Review of [RN B's] response

1. Role and routine

[RN B] lists her responsibilities in the Clinical Manager role and provides a breakdown of her daily routine. She also notes the responsibilities of other Registered Nurses employed at [the rest home] at the time of [Mr A's] admission including the Business and Care Manager, the two Charge Nurses and the Registered Nurses always rostered on the Hospital wing and the Restraint Co-ordinator.

She points out that she often worked weekends and was on call. She provides dates when she was required to be off site for annual leave, teaching, training and meetings. During these times her monitoring and supervision duties were covered by the Business and Care Manager.

This information shows clearly that [RN B] was not solely responsible for the monitoring of residents and supervision of staff. Responsibilities within the Clinical Manager role were shared with the Business and Care Manager while she was performing other duties within the role. She also relied upon the information provided at verbal and written handovers from the other RNs and the information contained in incident forms.

2. Care of [Mr A]

i. Admission

In my previous reports the appropriateness of [Mr A's] placement at [the rest home] facility has been discussed. [Ms G] (10 July 2019) states that comprehensive assessment of his needs prior to admission was not completed and that there was a discrepancy between his requirement of D6 or Hospital level care led to issues with caring for him.

[Mr A] was initially admitted for respite care prior to becoming a permanent resident. [RN B] points out that the initial discussion around admission for respite care was with the Business Manager not [RN B] as Clinical Manager. She also provides background for the decision to provide respite care at [the rest home], rather than a D6 unit, to assist with the transition from home to hospital care for the resident and family. She maintains that the [rest home] facility did have the resources and support to care for [Mr A] and disputes the assertion by Oceania that she should have consulted with Oceania Clinical and Quality team prior to accepting [Mr A] into permanent care. She reiterates that these decisions are at the Business Manager level and that it is not expected that facilities will check clinical decisions around admissions.

I accept that the interRAI assessment completed prior to [Mr A's] admission for respite care provided information to be used in recommending the level of care [Mr A] required. I also accept the rationale for choosing Hospital level over D6 for the respite placement. However, I still maintain that a further interRAI assessment after permanent placement be carried out to reassess whether D6 or continued Hospital level care given that there were concerns around the ability of staff to manage [Mr

A's] behaviour. I accept that the completion of an interRAI assessment is the responsibility of the primary Registered Nurse but the use of this assessment to identify a change in level of care would be initiated by the Clinical Manager.

[Ms G] (10 July 2019) states that the Person-centred care policy was not followed as a full care plan for [Mr A] was not completed within 3 weeks of his admission. This would have been true had [Mr A] been admitted as a permanent resident. As [RN B] rightly states an interim care plan is required for respite care and this was completed with a full care plan being completed within the expected timeframe following his permanent admission.

ii. Pressure areas

I accept that wound care protocols were followed upon the discovery of [Mr A's] pressure areas and that the District Nurses were working upon the advice of wound care specialists. However, I still maintain that initial preventative measures were unsuccessful. The responsibility for this lies initially with the RNs providing care. I am satisfied that [RN B] provided appropriate oversight once she had been made aware of the existence of [Mr A's] wounds. The prevention of these wounds needed to be based on [Mr A's] needs as a person with paraplegia.

iii. Fluid balance

I still maintain that given [Mr A's] specific needs, related to his spinal injury, that fluid balance should have been recorded made from his initial admission and on the advice of his wife. While I accept that there are protocols related to the monitoring of fluid balance, I believe that [Mr A's] case fell outside these bounds.

iv. Restraint

I accept that [RN B] was not responsible for the introduction of an inappropriate form of constraint for [Mr A] and that she moved to change the situation as soon as she was aware of the situation.

v. Recommendation

Upon review of [RN B's] response, I would like to alter my original findings to reflect that:

1. The responsibility for the shortcomings identified in [Mr A's] care lay with all Registered Nurses involved in his care including the Clinical Manager, Business Manager, Charge Nurses and Registered Nurses.
2. Documentation related to [Mr A's] permanent admission was appropriate and timely given that his initial admission was for respite care.
3. [RN B] in her role as Clinical Manager was not responsible or could not be expected to question the decision to admit [Mr A] into the facility.
4. [RN B] was not responsible for the provision of inappropriate restraint."

The following further advice was received from RN Parmee:

> "Thank you for the opportunity to provide further advice.
>
> 1. The buttock wound was found by the public hospital staff to be very deep, offensive smelling and unstageable.
>
> The information you have provided indicates that there was awareness of a wound two days prior to [Mr A's] admission to the public hospital, however it does not change my view that the monitoring and management of [Mr A's] buttock wound was inadequate, given that the wound had become deep, offensive and unstageable.
>
> 2. Thank you for providing the restraint monitoring records. This does not change my view about the appropriateness of the restraint used.
>
> Please let me know if you require further information.
>
> Kind regards
>
> **Rachel Parmee**"