

# **Radius Residential Care Limited**

**A Report by the  
Deputy Health and Disability Commissioner**

**(Case 18HDC01053)**



Health and Disability Commissioner  
*Te Toihou Hauora, Hauātanga*



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## Executive summary

1. This report considers the wound care and end-of-life care that was provided to a woman who developed multiple pressure injuries in 2017 while she was a resident of a rest home owned and operated by Radius Residential Care Limited. The report highlights the importance of ensuring that specialist input is sought in a timely manner for non-healing pressure wounds, and that clinical documentation is consistent and accurate. It also highlights the need for full and frank conversations about end-of-life care, and for involving family in a resident's palliative care journey, as appropriate.
2. Mrs A had advanced dementia and restricted mobility. She developed a pressure injury on her left heel and another pressure injury on her right heel three months later. Neither injury fully healed. Mrs A's pressure injuries became infected, and further ones developed on her sacrum and leg. She was reviewed by a wounds nurse specialist. Sadly, shortly after the specialist review, Mrs A deteriorated and died.

## Findings

3. The Deputy Commissioner found Radius in breach of Right 4(1) of the Code. In her view, a number of failings by staff demonstrated a pattern of poor care and poor compliance with policy, for which ultimately Radius was responsible.
4. The Deputy Commissioner also reminded the wounds nurse specialist of the importance of recognising the grief and emotions that a family may experience at the end of a loved one's life, and of ensuring that communications in that context are considered appropriately.

## Recommendations

5. The Deputy Commissioner recommended that Radius conduct a random audit of wound documentation; arrange wound care training for rest home staff; consider amending its communication policy to include the importance of family communication and documentation of the same; consider amending its pressure injury policy to include a more formal escalation process; arrange training for rest-home nursing staff on effective communication; and provide a written apology to the family.

## Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs B and Mr C about the services provided by Radius Residential Care Limited to their late mother, Mrs A. The following issue was identified for investigation:

- *Whether Radius Residential Care Limited provided Mrs A with an appropriate standard of care between Month5<sup>1</sup> and Month8 2017 (inclusive).*

7. 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.

8. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's daughter
Mr C	Complainant/consumer's son
Radius Residential Care Limited	Provider

9. Further information was received from:

RN D	Clinical Nurse Manager
RN E	Wounds Nurse Specialist
District Health Board	

Also mentioned in this report:

RN F	Registered nurse
Dr G	General practitioner
RN H	Registered nurse
RN I	Registered nurse
Dr J	General practitioner

10. Independent expert advice was obtained from Registered Nurse (RN) Sheryl Lilly and is included as Appendix A.

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## Information gathered during investigation

### Introduction

#### *Rest home*

11. The rest home, owned and operated by Radius Residential Care Limited (Radius), is contracted by the district health board (DHB) to provide rest-home, dementia, and hospital-level care.<sup>2</sup>

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<sup>1</sup> Relevant months are referred to as Months 1–8 to protect privacy.

*Mrs A*

12. In 2015, Mrs A (in her late seventies at the time) moved into rest-home-level care at the rest home.<sup>3</sup> On admission, Mrs A's medical history included chronic heart failure, vascular disease, mixed Alzheimer's (including vascular dementia and focal seizures), and chronic pain<sup>4</sup> in her hip and knees. She was a long-term smoker.
13. Mrs A was transferred to dementia-level care owing to cognitive decline.
14. On 23 Month1, an End of Life Needs care plan (the ELN Plan) was completed for Mrs A. The ELN Plan recorded the following details:
- “• [Mrs A] happy [to] receive analgesia to remain pain free
  - For cremation.”
15. In Month2, Mrs A was transferred to hospital-level care owing to her advanced dementia and restricted mobility resulting from peripheral oedema.<sup>5</sup> She required a two-person assist for all transfers, and was at risk of developing pressure injuries.
16. On 20 Month4, Mrs A's family first noticed a pressure area on Mrs A's left heel. RN F created a wound chart entry for this injury, noting that it was a stage 2<sup>6</sup> pressure injury and that it was to be assessed daily. Another nurse completed an incident form for the injury.
17. Radius's electronic wound chart enables nurses to record detailed observations of wounds, including measurements of the wound size, and descriptions of the wound bed tissue, exudate levels, and surrounding skin.

**Progression of left heel pressure injury**

18. Photographs were taken of Mrs A's left heel pressure injury regularly. The photograph taken on 2 Month5 showed an open wound with dark-coloured tissue. Wound evaluations documented on 2 Month5 and 4 Month5 noted that the wound had deteriorated.
19. The progress notes for Month5 show regular (usually daily) wound evaluations. The notes document that often Mrs A would refuse to have the wound evaluated or cleaned or the wound dressing changed.
20. On 27 Month5, the progress notes record: “Wound is healing nicely.” Further comments about the wound healing were recorded in the progress notes between 28 Month5 and 14

<sup>2</sup> At the time of events, the rest home's three-year certification from the Ministry of Health was due to expire in 2018. The rest home's current certification is due to expire in 2021.

<sup>3</sup> Owned and operated by Radius Residential Care Limited.

<sup>4</sup> From early 2017, Mrs A was prescribed 2.5mg of oral morphine daily for pain.

<sup>5</sup> The abnormal build-up of fluid causing swelling in the feet, ankles, and legs.

<sup>6</sup> A stage 2 pressure injury has partial thickness skin loss.

Month7.<sup>7</sup> However, Radius provided HDC with an undated handwritten note from Mrs A's clinical notes that stated that this wound "never fully healed".

### **Right heel pressure injury noted**

21. On 14 Month7, RN F wrote in the progress notes: "[W]ound dressing changed on right heel and made WCP<sup>8</sup> no care plan found for right heel." That day, RN F created a wound chart entry, noting that the wound was a stage 2 pressure injury and that it was to be assessed daily. HDC was not provided with evidence that Mrs A's family was notified of this pressure injury, or that an incident form was completed, which is required by Radius policy (relevant policies are set out in detail below).
22. On 15 Month7, the progress notes document necrotic tissue and low odour from the right heel pressure injury. Between 15 Month7 and 4 Month8, the injury was reviewed regularly, usually daily. However, the wound chart shows that complete observations of the wound were documented on only three occasions.<sup>9</sup> On 24 Month7, the wound bed tissue was noted to be 100% epithelialising,<sup>10</sup> with no wound exudate<sup>11</sup> and healthy surrounding skin. However, the following day, the wound chart records the wound bed tissue as 20% sloughy<sup>12</sup> with 80% eschar<sup>13</sup> and medium levels of wound exudate and macerated surrounding skin.

### **Review of interRAI assessment**

23. On 27 Month7, a review of the interRAI assessment<sup>14</sup> for Mrs A was carried out. The review noted that Mrs A was no longer walking and had one wound on each leg, resulting from skin breakdown related to peripheral oedema.

### **Deterioration – Month8**

24. On 2 Month8, it was noted that Mrs A had a stage 2 pressure injury on her sacrum and an injury to her left upper leg, the type and cause of which were documented as unknown. Radius told HDC, however, that this was another pressure injury. Wound charts were commenced for both injuries but the grade of the left upper leg injury was not recorded. HDC was not provided with evidence that Mrs A's family was notified of these injuries, or that any incident forms were completed.

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<sup>7</sup> The progress note entries on 26 Month5, 27 Month5, 3 Month6, 4 Month6, 8 Month6, 14 Month6, 17 Month6, 23 Month6, 4 Month7, and 14 Month7 record comments about the wound healing.

<sup>8</sup> Wound care plan.

<sup>9</sup> Complete observations of the wound were completed on 18, 20, and 25 Month7.

<sup>10</sup> Healing wound tissue.

<sup>11</sup> Liquid produced by the body in response to tissue damage.

<sup>12</sup> Dead tissue with a yellow or white appearance.

<sup>13</sup> Dead tissue usually with a black or dark appearance.

<sup>14</sup> Resident Assessment Instrument — a standardised instrument for evaluation of the needs, strengths, and preferences of residents in long-term care. The previous interRAI assessment for Mrs A was completed on 24 Month1 and noted a significant change in her status.

*Referral to wounds specialist*

25. On 2 Month8, a swab was taken from Mrs A's right heel pressure injury and sent to the laboratory for testing. On 4 Month8, Mrs A's right heel injury was noted to be unstageable.<sup>15</sup>
26. On 5 Month8, a referral was sent to the DHB for a specialist wound review of Mrs A's right heel pressure injury. On the same day, Clinical Nurse Manager RN D sent a section 31 pressure injury notification to HealthCERT.<sup>16</sup>

*Month8 — first medical review*

27. Also on 5 Month8, the laboratory reported to the rest home that the swab of Mrs A's right heel was positive for streptococcus<sup>17</sup> and enteric flora.<sup>18</sup> At 7pm, Mrs A's vital signs<sup>19</sup> were recorded. At 7.29pm, General Practitioner (GP) Dr G<sup>20</sup> reviewed Mrs A. Dr G noted that Mrs A's heel wounds were infected, and prescribed Augmentin, as well as oxycodone twice daily for pain.<sup>21</sup> The treatment plan also included "[review] if not settling".
28. Following this review, the progress notes show continued regular assessments of the left heel and sacrum pressure injuries. However, aside from the assessment by the wound nurse specialist (set out below), there were no further assessments of the right heel pressure injury until 13 Month8.<sup>22</sup>
29. On 6 Month8, RN D reviewed and updated Mrs A's care plan, including her skin care, pressure injury risk, pain, and medication.
30. On 9 Month8, the progress notes record that Mrs A had been "generally unwell" over the preceding weekend, and that Mrs B was informed of Mrs A's "decline".

*Month8 — second medical review*

31. On 10 Month8, Dr G reviewed Mrs A again. He noted Mrs A's "general decline" and "bed sores heels and hip, surrounding redness", and that Mrs A was not eating or drinking very much. Dr G met with Mrs A's family, and recorded having discussed with them Mrs A's general decline and that it was "difficult to tell how long it [would] take". He noted his plan to "aim [for] treatment in house only", and to continue with antibiotics and "sore cares".

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<sup>15</sup> An unstageable wound is a deep wound where the bottom of the wound cannot be seen because there is a layer of dead tissue covering it.

<sup>16</sup> Section 31(5) of the Health and Disability Services (Safety) Act 2011 requires certified providers to give written notice to the Director-General of Health of any incident or situation that puts at risk (or potentially could put at risk) the health or safety of people for whom the service is being provided.

<sup>17</sup> A type of bacteria.

<sup>18</sup> Bacteria originating from the intestines.

<sup>19</sup> Vital signs are the clinical measurements (pulse rate, temperature, respiration rate, and blood pressure) that indicate the state of a patient's essential body functions.

<sup>20</sup> Radius advised HDC that Dr G is not its employee.

<sup>21</sup> An antibiotic.

<sup>22</sup> A nurse commenced a new wound chart for the right heel pressure injury on 13 Month8. The chart shows that daily assessments of the wound were completed on 13–18 Month8.

*Review by wounds specialist*

32. RN E, a DHB wounds nurse specialist, visited the rest home on 12 Month8.<sup>23</sup> RN E's notes record that Mrs A's family were present for her review. RN E noted that the right heel had an unstageable pressure injury, 4.5cm by 4.5cm in size, and the left heel had a stage 2 pressure injury. According to RN E's notes, neither heel showed clinical signs of infection. She also noted that Mrs A's family had "report[ed] marked decline in health condition recently and voice[d] they [were] happy with comfort cares and no invasive treatment to wounds".
33. RN E's documented plan included a follow-up review in four to six weeks' time.
34. Mrs B and Mr C told HDC that RN E asked RN H, who was present at the review, the type of cream he was applying to Mrs A's right heel wound. According to Mrs B and Mr C, RN E told RN H:
- "[T]he cream was not doing any good and more likely progressing the condition that she referred to as 'Wet Gangrene' further and that applying Betadine would dry out the top layer and would only slow the progress down but the condition was fatal.
- ...
- We were told at this point that her condition was terminal for the simple fact she was too old to undergo intervention such as amputation. At this time we gave instruction to make her comfortable as possible as they told us there was no way to help her."
35. In response to the provisional opinion, Mrs B and Mr C stated that RN E told them that Mrs A's condition was fatal because of the wet gangrene.
36. In an earlier statement provided to HDC, Mrs B and Mr C also noted their concern about RN E's plan for a review in four to six weeks' time, and commented: "[I]t would have been known that [Mrs A] would not be alive in that timeframe."
37. The DHB told HDC:
- "There was concern that a gel had been used on the wound. [RN E] took the opportunity to do some in practice education with the facility staff present; this extended beyond [Mrs A's] condition and covered the negative impact that wet gangrene can have on a person. They also reviewed the need for wounds like [Mrs A's] to be kept dry. [RN E] does not remember sounding harsh, and that was not her intent."
38. RN E acknowledged that she "did use the word gangrene in her explanation to the family of the process of tissue death secondary to peripheral artery disease as it is a word people are familiar with". RN E apologised to Mrs A's family for any distress caused by the confusion that resulted from her comments about wet gangrene. RN E stated:

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<sup>23</sup> RN E entered the date of her visit as "12 [Month9]". However, this appears to be an error, as her entry is surrounded by other entries dated 12 Month8.

“4–6 weeks would be considered a standard length of time to follow up a patient’s response to the plan of care. While there was good reason to believe that [Mrs A] was in the last stages of life there is always a possibility of a person rallying.”

*Month8 — third medical review*

39. Later on 12 Month8, RN I recorded in the progress notes that Mrs A’s eldest son had requested a change from oral morphine to a morphine pump for Mrs A. RN I noted that staff were to organise a family meeting and a medical review.

40. On 15 Month8, GP Dr J<sup>24</sup> reviewed Mrs A. His notes include the following comments:

“[Mrs A] got quite unwell in the last 2 weeks when I was on leave. Seen by [Dr G] and has been placed on comfort care. The Rt heel is quite bad, deep wound and also gangrenous as per the staff. Today we tried to open her bandages but she appeared to be in a lot of pain so we left it at this present.

...

cellulitis treated with antibiotics with nil difference

poor blood supply with gangrenous wounds on her heels

gone downhill quite quickly

...

critically ill patient and family wants comfort care only.”

41. Dr J’s treatment plan included initiating a morphine pump, charting further morphine as required, and stopping all other medications. Dr J noted that Mrs A’s family were “happy with the plan”.

*Month8 — fourth medical review*

42. On 16 Month8, Mrs A was reviewed briefly by Dr J. Dr J noted Mrs A’s erratic breathing and unresponsiveness, and that the morphine appeared to have sedated her. He documented: “[Mrs A is a] critically ill patient, conveyed to the family again. We will try to keep her as comfortable as possible.”

43. An end-of-life pathway was commenced on 16 Month8. The pathway involved checking the infusion and cannula for Mrs A’s morphine pump, and addressing respiratory issues. On 17 Month8, the pathway was updated to include mouth cares.

44. Sadly, Mrs A passed away on 19 Month8. The direct causes of death were recorded as “[a]dvanced dementia, non-healing heel ulcers due to diminished blood supply to both legs/feet”. In response to the provisional opinion, Mrs B and Mr C drew attention to the fact that Mrs A’s death certificate also recorded the underlying cause of death (the disease

<sup>24</sup> Radius advised HDC that Dr J is not its employee.

or injury that initiated the train of morbid events leading to death) as “[n]on-healing, gangrenous ulcers of heels and lower legs”.

### **Further information**

#### *Mrs B and Mr C*

45. Mrs B and Mr C told HDC that they were not aware of further pressure injuries, other than Mrs A’s heel injuries, until they were provided with a copy of the DHB’s complaint outcome report (set out below). They were also not advised of the possibility of intravenous (IV) antibiotics to treat Mrs A’s infection. In addition, they were concerned at the lack of regular recordings of Mrs A’s vital signs, which prevented Mrs A’s infection from being detected, and therefore medical intervention being sought earlier.

#### *Radius’s policies in place at time of events*

46. Radius’s Pressure Injury Prevention Management and Skin Integrity Policy (the PI Policy) states:

#### **“8 Reporting**

...

8.2 Documentation is important to prevent pressure injuries or to prevent them from escalating. A resident centred approach is required at all times.

8.3 Any pressure area that develops, a full reassessment of the resident needs to be completed plus a wound assessment with the grade of the pressure area documented. A wound care plan is put in place. An incident form needs to be completed and the care plan updated.”

47. Radius’s Wound Care Policy (the WC Policy) provides that “[c]lients, family/whānau are to be involved in wound assessment and care planning and interventions are to be acceptable to the client”.

48. Radius’s End of Life Care Policy (the ELC Policy) states:

“A detailed nursing care plan is to be developed for all clients who require end of life care detailing the End of Life care needs which will include:

1. *Physical Support* — managing symptoms such as pain, sickness, tiredness or loss of appetite; good ‘tender loving care’ such as preventing pressure sores.
2. *Psychological Support* — giving emotional support to the resident and those who care about them, giving time to listen to them and understand their concerns.
3. *Social Support* — giving support and advice on practical matters such as getting their affairs in order.
4. *Spiritual Support* — a need to explore thoughts about the meaning of life, or concerns about what happens after death. All people are likely to have spiritual needs and some may also have practical things they need to do because of their religious beliefs.”

49. Radius told HDC that it considers that its ELC Policy requires “staff to involve family to the greatest extent possible in their loved one’s end of life/palliative journeys”. Radius also said:

“In our view, it was appropriate that conversations with [Mrs A’s] family regarding her prognosis/deterioration/care plan be led by medical staff, as is standard practice, with our [rest home] care staff repeating that messaging where necessary.”

*DHB investigation*

50. Mrs B and Mr C initially complained to the DHB about the care provided to Mrs A. As part of its complaint investigation, the DHB obtained a clinical nursing review and a geriatrician review of Mrs A’s clinical notes. In relation to the management of Mrs A’s pressure injuries, the clinical nursing review concluded:

“There appears to be appropriate escalation of care based on assessment and need. Both heels have an appropriate assessment and plan of care based on the goal of protection. The heels are stable for quite a while, there was appropriate escalation when they started to deteriorate with a swab being taken and antibiotics started on the 5<sup>th</sup> of [Month8] and the wound team were contacted.”

51. The review also suggested that, notwithstanding the above conclusion, the rest home should consider developing a more formal escalation process so that a wound care review is triggered. In relation to Mrs A’s end-of-life cares, the clinical nursing reviewer commented:

“A last days of life care plan was initiated. There were further interaction[s] with the GP on the 15<sup>th</sup> and 16<sup>th</sup> regarding a medication review to help improve [Mrs A’s] wound pain control. ... The family’s voice is hard to see on the record. ... Ways of capturing the family’s response and understanding within the record should be considered and support for the family built into the plan of care, especially for end of life.”

52. The geriatrician review commented that it was “difficult to decipher which heel pressure injury was referred to in the electronic documentation”, and that “[i]t was not clear if both pressure injuries were reviewed daily or only the pressure injury on the left”. The review also noted the lack of regular vital sign recordings in Month8. Specifically, the reviewer found that observations were taken only on 5 Month8 by Dr G, and on 11 Month8 by RN I (although the progress notes also record vital sign observations on 12 Month8 by RN H). The reviewer commented:

“The absence of regular observations would impair the ability of the staff to escalate the situation to the on-call doctor. ... The absence of any clear indication that the patient was for comfort care would confound any excuse not to perform regular observations between the times when the heel pressure injury was first seen until 10 [Month8].”

53. In relation to communication with Mrs A's family about the decision to cease active treatment, the geriatrician reviewer commented:

"It would be incumbent for [rest home] management to resolve as to the content of the discussion between the family and the medical practitioner. ... There was no further allusion in the notes nor was it specifically mentioned that [Mrs A] would be for comfort cares between [Dr J's notes on 10 Month8] and the next medical practitioner notes on 15 [Month8]."

54. The DHB provided HDC with a copy of its complaint outcome report (the COR). The COR's key findings were recorded as:

"[Radius] was found to be in breach of the Age-related Residential Care contract primarily because staff did not adhere to policies and procedures. The related clauses are listed below with the key aspect in brackets:

- D16.3f) [family input into care planning];
- D 16.3h) [care plan addresses 'care of the dying'];
- D16.5a) [care is focused on the resident's needs and supports dignity and autonomy];
- D17.7a) [staff follow facility procedures and protocols re wound management, documentation and observations]."

55. The COR recommended a number of corrective actions for Radius, including that it undertake a critical review and audit of its policies and procedures that relate to:

- Pain assessment and documentation.
- Wound assessment, including site measurement and photographic documentation.
- Wound treatment of both wet and dry gangrene.
- Communication with families about end-of-life care, and documentation of same.
- Communication between specialist staff and facility staff and documentation of same — including how that communication is relayed to a resident and their family and to a visiting GP.

56. The COR also noted that RN E's "communication to the family and documentation created anxiety and confusion of interpretation of information provided".

#### *Radius*

#### Corrective Action Plan

57. Radius told HDC that following the COR recommendations it created a Corrective Action Plan (CAP). The CAP noted that wound assessment documentation was not being completed consistently. Radius told HDC that it has now implemented all of the corrective actions.

### Responses to provisional opinion

58. Mrs B and Mr C, Radius, and RN E were given an opportunity to respond to relevant sections of the provisional opinion. Where appropriate, changes have been incorporated into this report.
59. Mrs B and Mr C commented:
- “Because of [the rest home’s] lack of medical care [Mrs A’s] right heel pressure sores progressed into wet gangrene. If [Mrs A’s] vital signs etc. were monitored and documented right from the start the rest home would have picked up that [Mrs A] was going into septic shock — then progressing into Septicaemia causing death.”
60. Radius advised that it had nothing further to add.
61. RN E also advised that she had nothing further to add, and that she has taken the opportunity to consider the Deputy Commissioner’s comments in her practice.

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## Opinion: Radius Residential Care Limited — breach

### Introduction

62. In accordance with the Code of Health and Disability Services Consumers’ Rights (the Code), Radius had a responsibility to operate the rest home in a manner that ensured that services were provided to its residents with reasonable care and skill.

### Wound care

#### *Escalation to wounds nurse specialist*

63. My expert advisor, RN Sheryl Lilly, noted that Mrs A had pressure areas present from Month5. However, the referral for wounds nurse specialist review was not sent until 5 Month8, when Mrs A’s right heel pressure injury had become unstageable and had infection present, and she had developed further pressure areas on her sacrum and left upper leg.
64. RN Lilly advised:

“There are no set guidelines when assessing the length of time a wound should take to heal and when interventions need to be escalated. Health, nutrition, hydration and skin condition are some aspects that need to be taken into account, an RN should then use critical thinking to evaluate wound progress or lack thereof and consider other options.

Considering the length of time the pressure areas were present and seemingly not improving I am critical of the time it took to send a referral and to engage other health professionals. I consider it a moderate departure from accepted practice.”

65. In mitigation, I note that Mrs A's left heel pressure injury, after deteriorating in early Month5, appeared to be healing between Month5 and Month8 (although it never fully healed). I also note that the DHB's clinical nursing advisor concluded that the rest home had escalated Mrs A's care appropriately.
66. However, by the time Mrs A's right heel pressure injury was first documented on 14 Month7 (and this injury appears to have been present for an unknown length of time before then),<sup>25</sup> the left heel pressure injury had been present for nearly three months without fully healing. The referral for wounds specialist review was sent on 5 Month8, by which time the right heel pressure injury had deteriorated into an unstageable injury and Mrs A had also developed a stage 2 pressure injury on her sacrum. In my view, the opportunity for prompt escalation and intervention for Mrs A's pressure areas was missed. I therefore accept RN Lilly's advice, and I am critical that Radius staff failed to request specialist review of Mrs A's pressure areas earlier.

#### *Documentation*

67. Wound chart and progress note entries for both heel pressure injuries were completed regularly by various Radius staff, but often contained incomplete or conflicting information. For example:
- The progress notes indicate that the right heel pressure injury had been present for a period of time before it was documented and a wound chart was commenced.
  - Between 14 Month7 and 4 Month8, the wound chart for the right heel pressure injury contained complete observations of the wound on only three dates: 18, 20, and 25 Month7.
  - On 24 Month7, the wound chart for the right heel pressure injury indicated that it was healing. However, the following day, the wound chart records that the wound bed tissue was 20% sloughy with 80% eschar, medium levels of wound exudate, and macerated surrounding skin.
  - Between 5 Month8 and 13 Month8, the right heel pressure injury was not assessed.
68. RN Lilly advised that the clinical documentation did not always "provide clear evidence of the care planned, the decisions made, the care delivered and the information shared, with rationale for the nursing action and/or inaction". RN Lilly considered this a minor departure from accepted practice. She also suggested that Radius review with its nurses and caregivers the need for subjective content in reporting, to better reflect the care actually given, rather than relying heavily on tick-box forms. I accept this advice, and I am critical of the standard of documentation of Mrs A's wound care.

#### *Compliance with policy*

69. Radius's PI Policy highlights the importance of documentation in the prevention of pressure injuries and the escalation of pressure injuries. If a resident develops a pressure

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<sup>25</sup> The progress notes record: "[W]ound dressing changed on right heel and made WCP no care plan found for right heel." See paragraph 21 above.

area, the PI Policy requires a full reassessment of the resident and an update of the care plan, as well as completion of a wound assessment, including the grade of the wound, a wound care plan, and an incident form. The WC Policy requires the input of both the resident and the resident's family into wound assessment and care planning.

70. I note RN Lilly's advice that Radius's relevant policies met the required standards. However, I also note that there were a number of instances where the care provided to Mrs A was inconsistent with the PI Policy and WC Policy:
- There is no evidence that Mrs A's family was notified of Mrs A's right heel pressure injury on 14 Month7, or of the sacrum and left upper leg pressure injuries on 2 Month8.
  - There is no evidence that Mrs A was fully reassessed, and her care plan updated as required, when the right heel pressure injury was first noted on 14 Month7 (although I note that RN D updated the care plan on 6 Month8).
  - The left upper leg pressure injury was not documented as a pressure injury, and the grade of the injury was not recorded.
71. This pattern of non-adherence to Radius's policies is concerning. As this Office has stated previously,<sup>26</sup> inaction and failure by multiple staff to adhere to policies and procedures points towards an environment that does not support and assist staff sufficiently to do what is required of them and ensure that its residents consistently receive optimal support.

#### **End-of-life care**

72. On 9 Month8, the progress notes show that Mrs A's health had declined over the preceding weekend.
73. On 10 Month8, Mrs A was reviewed by Dr G. Dr G discussed Mrs A's general decline with her family, and documented the plan as "treatment in house only".
74. Following this, the progress notes do not show any discussions about palliative or end-of-life care until the review by RN E. RN E noted that Mrs A's family were happy with comfort cares and no invasive treatment to Mrs A's wounds.
75. The next documented discussions with Mrs A's family about her end-of-life care were held with Dr J on 15 Month8 and 16 Month8.
76. The ELC Policy requires a detailed nursing care plan to be developed for all clients who require end-of-life care. The care plan is to include details on the physical, psychological, social, and spiritual support required. Radius told HDC that it considers that the policy requires "staff to involve family to the greatest extent possible in their loved one's end of life/palliative journeys".

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<sup>26</sup> 16HDC01380.

77. RN Lilly advised:

“The progress notes evidence that the GPs discussed with ‘the Family’ the decline of [Mrs A] and carrying out comfort cares or ‘in house cares only’. There is no evidence of further discussion with the family by [the rest home] staff around last days of life or what the plan of care was for [Mrs A], there may have been verbal discussion but it was not documented.

... The importance of communication between staff and the dying person, and those identified as important to them cannot be over emphasized.”

78. RN Lilly considered this a mild departure from accepted practice. She also suggested that Radius review its communication policy to include a template that clearly covers in detail the content of discussions with residents and their family. RN Lilly noted that this level of detail is important not only for end-of-life discussions but also for day-to-day occurrences.

79. I accept RN Lilly’s advice. In doing so, I also note similar comments made by the DHB’s clinical nursing and geriatrician advisors. Specifically, the nursing advisor commented that Mrs A’s family’s voice was hard to see on the record, particularly in relation to end-of-life care. The geriatrician advisor noted that other than the medical review notes, the progress notes do not contain reference to discussions about Mrs A receiving comfort cares only. The geriatrician advisor commented that Radius had an obligation to confirm what was discussed between Mrs A’s family and Dr G and Dr J in relation to the decision to cease active treatment.

80. I also acknowledge Mrs B and Mr C’s concern that they were not advised of the possibility of IV antibiotics to treat Mrs A’s infection. In my view, a full and frank conversation between Radius staff and Mrs A’s family about the decision to cease active treatment would have been a key opportunity to address any outstanding concerns or questions. Unfortunately, due to the lack of documented discussions, it is not possible to determine whether such a conversation occurred.

81. It is disappointing that Radius staff failed to document any discussions with Mrs A’s family about their wishes for her end-of-life care. I note that this is contradictory to Radius’s expectation that staff will involve family in a resident’s palliative journey to the greatest extent possible.

### **Conclusion**

82. I consider that the failures by Radius staff, summarised below, demonstrate a pattern of poor care and poor compliance with policy, and Radius must bear overall responsibility for this. In my view, Radius failed to provide Mrs A with services with reasonable care and skill in the following ways:

- Radius staff failed to request specialist review of Mrs A’s pressure areas earlier.
- Clinical documentation for the heel pressure injuries often contained incomplete or conflicting information.

- The wound care provided was at times inconsistent with the policies.
- There is no evidence of Radius staff having discussed Mrs A's end-of-life care with either Mrs A or her family.

83. Accordingly, I consider that Radius breached Right 4(1)<sup>27</sup> of the Code.

#### **Lack of vital sign observations in Month8 — adverse comment**

84. Mrs A's vital signs were recorded on only three occasions in Month8 — on 5 Month8 by GP Dr G, and on 11 Month8 and 12 Month8 by Radius staff. I note Mrs A's family's concern that the lack of regular vital sign observations may have meant that Mrs A's infection was not identified earlier, and therefore her care was not escalated for medical intervention appropriately. I also note the DHB's geriatrician advisor's comment that the lack of regular observations would impair the ability of Radius staff to escalate Mrs A's care appropriately. I agree, and I am critical that Radius staff did not take regular vital sign observations before it was confirmed with certainty that Mrs A was to receive comfort cares only.

#### **Opinion: RN E — other comment**

85. RN E reviewed Mrs A's wounds on 12 Month8. During the review, she educated Radius staff on wound care and, specifically, the need to ensure that wounds such as Mrs A's were kept dry. RN E also documented a plan of care, which included follow-up in four to six weeks' time.
86. Mrs B and Mr C told HDC that they heard RN E say that wet gangrene was present and that it was fatal. They also told HDC that RN E would have known when she made the follow-up plan that Mrs A would no longer be alive in that timeframe.
87. Conversely, the DHB told HDC that RN E's discussion went beyond Mrs A's case and included a discussion about the effects of wet gangrene. RN E told HDC that four to six weeks is a standard timeframe for follow-up review, and that although Mrs A was in the last stages of her life, there was the possibility of her improving.
88. The DHB acknowledged to HDC that RN E's documentation and communication to Mrs A's family created anxiety and confusion of interpretation of the information provided.
89. Because of the conflicting accounts, I am unable to determine whether RN E specifically said that Mrs A had wet gangrene in her wounds. I nonetheless accept that RN E was intending to educate Radius staff about wound care, and that she could not have known with certainty when Mrs A would pass away.

<sup>27</sup> Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

90. My expert advisor, RN Lilly, advised that the care provided by RN E was appropriate. However, in my view, RN E should have appreciated that it may have been alarming for Mrs A's family to hear the words "wet gangrene" at that time, and particularly in the context of the end-of-life stage. RN E should also have recognised that the timeframe for follow-up could have created confusion for the family in terms of Mrs A's prognosis. I remind RN E of the importance of recognising the grief and emotions that a family may experience at the end of a loved one's life, and of ensuring that communications in that context are considered appropriately.
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## Recommendations

91. I recommend that Radius:
- a) Provide a written apology to Mrs A's family for the failures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.
  - b) Conduct a random audit of wound documentation for ten residents over the past six months, to ensure compliance with relevant Radius policies. Radius is to report the results of the audit to HDC within three months of the date of this report.
  - c) Arrange a wound care training session for rest home staff. The session should specifically cover the management of pressure areas, documentation of wounds, and escalation of care. Radius is to provide evidence to HDC, within three months of the date of this report, that the training has occurred or has been scheduled.
  - d) Consider whether its communication policy should be amended to include the importance of family communication and documentation of the same, especially in the context of end-of-life/palliative care. Radius is to report the results of the review to HDC within three months of the date of this report.
  - e) Consider whether its PI Policy should be amended to include a more formal escalation process for triggering wound specialist or medical review of pressure injuries. Radius is to report the results of the review to HDC within three months of the date of this report.
  - f) Arrange training sessions for rest-home nursing staff on effective communication with family members, particularly in the context of end-of-life/palliative care. Radius is to provide evidence to HDC, within three months of the date of this report, that the training has occurred or has been scheduled.
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**Follow-up actions**

92. A copy of this report with details identifying the parties removed, except Radius Residential Care Limited and the expert who advised on this case, will be sent to the district health board, and it will be advised that this report relates to the rest home.
93. A copy of this report with details identifying the parties removed, except Radius Residential Care Limited and the expert who advised on this case, will be sent to the Ministry of Health (HealthCERT) and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.

## Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Sheryl Lilly:

### “1. Disclaimer

I, Sheryl Lilly, have been asked to provide an opinion to the Commissioner on case number C18HDC01053 and I have read and agree to follow the Commissioner’s guidelines for Independent Advisors. I have no known personal or professional conflict in this case.

### 2. Expert’s Background

I have been a New Zealand Registered nurse for Thirty years with a background in clinical care and aged care nursing management. I am an owner/operator of a 20 bed rest home for the past twelve years and also own another 28 bed facility, that I purchased 6 years ago. I am also a Career Force assessor.

### 3. Instructions from the Commissioner

I have been asked to review the documentation sent to me and advise whether I consider the care provided to [Mrs A] was reasonable in the circumstances, and why. In particular please comment on:

1. The referral by Radius for a wounds specialist to review [Mrs A’s] pressure injuries.
2. The reasonableness of the care provided to [Mrs A] by wounds specialist [RN E] on 12 [Month8].
3. The planning and implementation of [Mrs A’s] wishes as to her end of life care, including management of pain.
4. The overall standard of care provided to [Mrs A] during 2017 and in particular during the approximately two week period leading up to her death.
5. The overall standard of documentation and communication between the rest home staff and [Mrs A] and her family.
6. The adequacy of Radius’s relevant policies and procedures.
7. Any other matters in this case that you consider warrant comment.

### 4. Factual summary

In 2017 [Mrs A] developed a number of pressure injuries. On 5 [Month8] a right heel pressure injury was swabbed and was positive for streptococcus bacteria. Antibiotics were charted and the GP noted that [Mrs A] was generally declining, and was for comfort cares.

A wound specialist reviewed [Mrs A] on 12 [Month8] and documented a management plan for her, noting that she was for comfort cares and the family was happy with that.

The GP reviewed [Mrs A] on the 15<sup>th</sup> and 16<sup>th</sup> of [Month8], noting [Mrs A] was critically ill and that the plan discussed with [Mrs A's] family was one of comfort cares. [Mrs A] passed away on the 19 [Month8].

## 5. Expert Review

### 5.1 The referral by Radius for a wounds specialist to review [Mrs A's] pressure injuries.

There is evidence of a wound referral sent to the wound specialist on the 5<sup>th</sup> [Month8]. On reviewing the wound care plans, progress notes and photos of the pressure areas, there is evidence that the pressure areas were present on the 20<sup>th</sup> of [Month5]<sup>1</sup>, they were assessed as stage two pressure injuries. A photo taken of the left heel on the 27<sup>th</sup> of [Month5] and then again on the 2<sup>nd</sup> of [Month6] shows a deterioration of the wound. It is unclear how the pressure areas progressed, but there is evidence of a wound chart with a start date of 14 [Month7] which the referral form has as the accident date.

There are no set guidelines when assessing the length of time a wound should take to heal and when interventions need to be escalated. Health, nutrition, hydration and skin condition are some aspects that need to be taken into account, and an RN should then use critical thinking to evaluate wound progress or lack thereof and consider other options.

Considering the length of time the pressure areas were present and seemingly not improving I am critical of the time it took to send a referral and to engage other health professionals. I consider it a moderate departure from accepted practice.

### 5.2 The reasonableness of the care provided to [Mrs A] by wounds specialist [RN E] on 12 [Month8]

On reviewing the wound review notes written by the wound nurse [RN E]<sup>2</sup> there is evidence of an assessment that included history, foot assessment, wound assessment and a plan established. The family were present and contributed to the information needed for the assessment. This meets accepted standard of care.

Considering the fact that it appears that the wound nurse, [RN E] discussed treatment with the attending family members and stated the family were happy with comfort cares and no invasive treatment, I consider the care provided by the wound nurse to be reasonable.

### 5.3 The planning and implementation of [Mrs A's] wishes as to her end of life care, including management of pain.

There is brief documentation of [Mrs A's] end of life wishes. It is noted that she is happy to receive pain relief to remain pain free and is for cremation. There is no evidence of family involvement as per their end of life care policy<sup>3</sup> and is only reviewed two yearly.

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<sup>1</sup> Radius A/I form dated 20 Month5

<sup>2</sup> Progress notes, wounds date 12 Month8

<sup>3</sup> End of Life, clinical manual Doc.No. 31

There has recently been an increased amount of work done on guidelines around planning and implementing last days of life care. There are easily accessible templates to assist facilities to provide advanced care planning opportunities<sup>4</sup> that ensure the resident's wishes will be met. This can also open up opportunities to discuss with families the future expectations of care for their family member as that family member's health declines. It is also an opportunity for education around what is meant by comfort cares and palliative care, and this communication can then avoid misunderstandings during a stressful time when thinking is not always clear and emotions are running high. Although the rest home has evidence of documentation around end of life needs there is room for improvement to better meet best practice for successful palliative care. The document I have reviewed contained very little information and no evidence of family communication. If a resident cannot speak for themselves, this should be documented and family wishes recorded. If this is the only document used by the rest home for advanced care planning I recommend they review this and perhaps look at the Ministry of Health site for a better template.

There is evidence in [Mrs A's] care plan around how to recognise if she is in pain. There is evidence of recognition of [Mrs A] having chronic pain and her medication chart evidences regular pain relief and PRN pain relief as both charted. There is evidence in the progress notes during her last days of life that a syringe pump was started and PRN morphine being administered, for breakthrough pain, although there does not appear to be any formal pain assessment and outcome chart there is efficacy noted after PRN pain relief is given. There is also documentation to evidence a GP review around pain relief. My peers and I consider this meets accepted practice in this situation.

*5.4 The overall standard of care provided to [Mrs A] during 2017, and in particular during the approximately two week period leading up to her death.*

On reviewing [Mrs A's] care plan, the assessment and planning cover all necessary elements for holistic care, dates on the care plan evidence timely evaluations and meet the standard required.<sup>5</sup> There is documented evidence of appropriate cares carried out as per the care plan, including ongoing wound care, attention to nutrition, hydration and general comfort. Apart from the identified need to escalate the wound care sooner, as discussed above, the care provided to [Mrs A] during 2017 prior to the two weeks leading up to her death meets the accepted standard of care.

On reviewing [Mrs A's] progress notes from the 28<sup>th</sup> [Month7], she remained stable until a decline was noted on the 9<sup>th</sup> [Month8].<sup>6</sup> [Mrs A's] health was documented by the visiting GP to be in a general decline on the 10<sup>th</sup> [Month8] <sup>7</sup> and the family were aware of this and agreed to 'in house cares only'. Pain relief was checked for efficacy and on the 15<sup>th</sup> [Month8] a syringe driver was commenced to ensure best possible comfort. Caregiver documentation indicates comfort cares being met, including hygiene, oral

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<sup>4</sup> Health, Quality and Safety Commission ACP.

<sup>5</sup> HDSS Continuum of Service Delivery

<sup>6</sup> Progress notes 9 [Month10] RN

<sup>7</sup> Progress notes 10 [Month10] [Dr G]

cares and positioning. There is documented evidence of family in attendance and wanting to participate in their mother's care during her last days of life.

I consider that the rest home met the expected standard of care. However, I would recommend a review with nurses and caregivers on the need for subjective content in their daily reporting to better reflect the care actually given, rather than relying heavily on the tick box form of e-care.

5.5. The overall standard of documentation and communication between the rest home staff and [Mrs A] and her family.

During my investigations I have found the electronic documentation system difficult to follow. It is the author's responsibility to 'provide clear evidence of the care planned, the decisions made, the care delivered and the information shared, with rationale for the nursing action and/or inaction'.<sup>8</sup> The electronic documentation does not always clearly evidence this, and I consider this a minor departure from accepted practice.

I would recommend a review of the use of e-case documentation and how best to ensure a clear picture of nursing cares, actions and outcomes.

There is some reference to 'the family' at times in the progress notes, but no reference to any conversations taking place around [Mrs A's] ongoing deterioration or explanation of cares.

As I have previously stated, the importance of communicating the meaning of comfort cares, palliative care or in this instance, the GP's words 'in house treatment only' cannot be emphasised enough. Discussion around dying can be difficult, but with allowing time with the family for questions, explanations and empathy, confusion and anger post death is almost always avoided.

There is a common problem amongst Aged Care Facilities around how nurses and doctors communicate to families around death and dying. Health professionals often use phrases such as 'not too well' which can be misinterpreted by families. Where health professionals recognise a person may be dying, they must ensure that the person and their relatives have the opportunity to understand that possibility.

I consider that the standard of care around communication<sup>9</sup> has not been met and consider this a moderate departure from accepted practice.

I recommend a review of the communication policy that includes a template that clearly states what discussions have taken place, with whom and when and around what subject. This is important not only for end of life discussions but with day to day occurrences.

<sup>8</sup> NZNO Practice Publication Label: Guideline: Documentation, 2017 New Zealand Nurses Organisation PO Box 2128, Wellington 6140. [www.nzno.org.nz](http://www.nzno.org.nz)

<sup>9</sup> Health and Disability Code of Rights 6 and 7

5.6 The adequacy of Radius's relevant policies and procedures.

Radius's policies around pain management, Pressure Injury Prevention, Communication, and end of life care met required standards.

On reviewing the policy on communication, the emphasis is on communicating with the resident. I would recommend a review around extending the policy to include the importance of family communication and the documentation of the same.

This could also extend to the End of Life care policy. The importance of communication between staff and the dying person, and those identified as important to them cannot be over emphasized.<sup>10</sup>

**Sheryl Lilly"**

The following further advice was obtained from RN Lilly:

"There is currently no clear mandate around End of Life Wishes and its required documentation, only guidelines; however, if the facility's End of Life policy is clear around the information required in respect of input from both the resident concerned and/or their family and this was not done, then the facility is in breach of their policy and I would consider this a minor departure considering that the actual end of life care did meet accepted practice even if the documentation did not."

The following further advice was obtained from RN Lilly:

"Further Review 19/8/19

Thank you for the opportunity to further review my comments.

I was asked to comment on *'the referral by Radius for a wounds specialist to review [Mrs A's] pressure injuries'*.

Further to my comments made in my initial advice to HDC, I would like to reiterate the reasons I felt that the wound intervention should have been escalated sooner. The initial pressure areas were noted on the 20<sup>th</sup> [Month4] as stage 2 pressure injuries, there were photos taken on the 27 [Month5] and the 2<sup>nd</sup> of [Month6], both showing, in my opinion, deterioration of the wounds. Although [Mrs A] had other health issues that were impacting on her healing abilities<sup>11</sup>, the opportunity to try and improve the pressure areas would have been more timely at stage 2 before advancing to a more difficult wound to deal with. The referral was not done until three months after the initial documentation, when an infection had set in and the wounds had started to deteriorate further to unstageable. I consider that the timeframe between identifying the pressure areas at stage 2, the areas seemingly not improving, and then waiting until they deteriorated to unstageable to be a moderate departure from accepted practice.

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<sup>10</sup> MOH Te Ara Whakapiri, Principles and guidelines for the last Days of Life.

<sup>11</sup> Radius Care Chronology

I was also asked to comment on *'the overall standard of documentation and communication between the rest home staff and [Mrs A] and her family'*.

In addition to my comments made in my initial advice to HDC, I would like to add:

The progress notes evidence that the GPs discussed with 'the Family' the decline of [Mrs A] and carrying out comfort cares or 'in house cares only'. There is no evidence of further discussion with the family by [rest home] staff around last days of life or what the plan of care was for [Mrs A]; there may have been verbal discussion but it was not documented.

On further review and considering the fact that the family acknowledged the deterioration of [Mrs A]<sup>12</sup> and there is documented evidence that the GP discussed comfort cares with the family but there is no documented evidence of [rest home] staff doing so, I now reconsider that this was a mild departure from accepted practice.

**Sheryl Lilly RN"**

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<sup>12</sup> Mrs A's son's email dated 12 Month8