HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A decision by the Aged Care Commissioner

(Case 22HDC02310)

Introduction

1. On 12 September 2022 this Office received a complaint from Ms A about the care provided to her grandmother, Mrs B (aged 85 years at the time of events), while she was a resident at Oceania Care Company Limited (trading as Elmwood Village).

2. The following issues were identified for investigation:

- *Whether Oceania Care Company Limited (trading as Elmwood Village) provided [Mrs B] with an appropriate standard of care in April–May 2022 (inclusive).*
- *Whether [RN C] provided [Mrs B] with an appropriate standard of care in April–May 2022 (inclusive).*
- *Whether [NP D] provided [Mrs B] with an appropriate standard of care in April–May 2022 (inclusive).*

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

Background

4. Mrs B's medical history included asthma, dyslipidaemia,[1] hypertension,[2] benign paroxysmal positional vertigo (BPPV)[3] and cataracts.[4] She also had had a stroke,[5] which caused left-sided paralysis.

5. Prior to the stroke, Mrs B was independent and living with her family, but the left-sided paralysis caused by the stroke affected her mobilisation, and Mrs B became 'bedbound' and needed full support with her cares, including eating, drinking, showering, and toileting, and full assistance to reposition herself in bed to prevent pressure injuries forming.

6. Due to the stroke symptoms, Mrs B was admitted to Elmwood Village (Elmwood) on 20 April 2022.

[1] High levels of cholesterol or fats (lipids) in the blood.
[2] High blood pressure.
[3] Episodes of dizziness and a sensation of spinning with certain head movements.
[4] Clouding of the lens of the eye, which typically is clear.
[5] Damage to the brain from an interruption of its blood supply.

Mrs B's admission into Elmwood Village

7. Mrs B was admitted into hospital-level care at Elmwood.

8. Oceania told HDC that several of Mrs B's admission assessments were completed on admission (such as her mobility and transfers assessment, pain assessment, pressure injury risk assessment, and skin assessments). However, Mrs B's assessment documentation was reviewed as part of this investigation (see Appendix B). As reflected in the table:

- Out of 13 assessments that should have been completed, only one assessment was completed (dietary assessment).
- Out of the four assessments Oceania noted as having been completed, HDC did not receive documentation supporting this.[6]

9. As noted in the Age-Related Residential Care Services (ARRC) agreement, resident assessments are to be completed on admission to a facility, so that the registered nurse can complete the resident's initial care plan to cover a period of up to 21 days.

10. Oceania told HDC:

> 'Contrary to our standard practice, no initial care plan or interim care plan was started on [Mrs B's] admission … As there were no completed care plans for [Mrs B], Healthcare Assistants (HCAs) were not guided to complete the required monitoring for [Mrs B]. This falls short of Oceania's expected best practice.'

11. Oceania stated: '[N]ursing staff did not follow Oceania policies and procedures, particularly in terms of completing the interim care plans on admission and starting monitoring charts.' Oceania noted that according to its policy, interim care plans are to be completed within 24 hours, and full care plans are to be completed within 21 days. Oceania told HDC that this meant that carers were unaware that they needed to complete appropriate tasks for Mrs B.

Environmental safety and management of Mrs B's risk of falling

12. On 21 April 2022 progress notes document that Mrs B was reviewed by the physiotherapist. In terms of transfers, the physiotherapist recommended using a full hoist to transfer her to a tilt-and-space wheelchair. In terms of bed mobility, the physiotherapist recommended that Mrs B be assisted by two people using slide sheets. Although the physiotherapist noted that because of Mrs B's '[d]ense weakness of [the] left side [of her body]' it was important to keep her in a good position, no specific instructions were provided regarding pressure-relieving equipment, or guidance on how often Mrs B should be repositioned.

13. On 22 April 2022 a subsequent review by a different physiotherapist noted that Mrs B was for 'regular turns and transfers up to [a] fall out chair', but no guidance was provided on how often (hourly or two-hourly, for example) she should be repositioned or transferred.

[6] Oceania noted that the assessments 'About me', 'Leisure', and 'Life History' were also completed. However, HDC did not receive copies of these assessments for review, so these are not included.

14. Oceania told HDC that residents' beds are 'routinely moved against the wall for a few residents' so that it can assist in the placement of sensor mats as a fall prevention strategy, as used by Oceania routinely.

Pressure injury prevention

15. As a result of her stroke, Mrs B also needed pressure-injury prevention care, such as regular two-hourly repositioning.

16. Oceania told HDC:

> 'We do note from the progress notes that HCAs were providing pressure injury preventative cares … and regular visual checks on [Mrs B]. However, it is unknown if this was carried out two hourly as no pressure care charting was started over this period. Similarly, it is not known if visual checks were carried out two hourly as there is no evidence of this under charting.'

17. Entries in Mrs B's progress notes that mention when she was repositioned for pressure injury management, and when visual checks were completed, is included as a table in Appendix C. The table also notes when staff documented which side of her body she was turned on to, and whether staff documented the frequency of her turns (eg, two-hourly, hourly, etc).

18. Mrs B's pressure area management and visual check entries were tracked over a one-month period, from 20 April 2022 to 21 May 2022. As reflected in the table, 49 entries mentioned when Mrs B was repositioned:

- Out of the 49 entries, 12 entries noted the frequency of Mrs B's turns.
- Out of the 49 entries, only 7 entries noted which side of her body Mrs B was turned on to.

19. Oceania told HDC: '[B]ecause Elmwood was in lockdown over this period due to a COVID-19 outbreak all residents were visually monitored more frequently.'

20. The following agreement and policies relate to admissions, assessments, care planning process, and pressure injury risk management.

Agreement and policies

ARRC Agreement (updated) 2023–2024

21. Health New Zealand|Te Whatu Ora (Health NZ) contracts with aged residential care providers for delivery of services to older people via the Age-Related Residential Care Services Agreement (ARRC) 2023–2024. Section D16.2 of this agreement states that registered nurses are responsible for creating care plans, and that 'each Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 21 days'.

Person-centred care planning policy (issued May 2021, reviewed March 2022)

22. At the time of events, Elmwood had a person-centred care planning policy, the purpose of which was to minimise risk to the resident, staff, and organisation by ensuring that comprehensive care plans were developed based on thorough assessments of the resident's needs.

23. The policy documents that an interim assessment is to be completed within 24 hours of a resident's admission, highlighting any alerts or risks. A comprehensive assessment is then to be undertaken over the first 21-day period from admission, to gather relevant information in order for a registered nurse to develop the care plan.

Pressure Injury Risk Management and Skin Care Policy (issued July 2021, reviewed March 2022)

24. At the time of events, Elmwood had a Pressure Injury Risk Management and Skin Care Policy, the purpose of which was to 'maintain or improve the skin integrity of all residents using regular risk assessments and implementing person centred preventative measures'.

25. The policy documents that a pressure-injury assessment and monitoring form must be completed along with a pressure-injury care plan. It also documents that a pressure-injury register is to be maintained for pressure injuries of grade 1–2.

Sentinel event 28 April 2022 — management of Mrs B's burn injury

Sentinel event timeline

26. From 22 April 2022 to 6 May 2022 Elmwood was in lockdown due to a second wave of COVID-19. Residents' families could not visit during this time and instead had to rely on phone calls for updates.

27. On 28 April 2022 the afternoon carers completed Mrs B's hygiene cares and then assisted her into bed around 8.00pm. The carers moved Mrs B's bed against the wall, so that she would 'not roll off the bed' during the night. The carers did not notice that the bed was placed right next to the heater, which did not have a guard on it. Oceania told HDC that Mrs B's room had recently been renovated prior to her occupying the room. The heater guard had been removed so that the heater could be painted, but the guard had not been replaced afterwards.

28. At 1.30am on 29 April 2022 a carer checked on Mrs B and noticed that her left leg had slipped down between the heater and the bed, and that she had sustained a large second-degree burn to her leg.

29. This was reported to RN E, who 'examined the wound, provided first aid, dressed the wound, started a wound chart' and completed an incident form. The wound chart required care and review of Mrs B's burn injury every two days. RN E instructed staff to keep Mrs B hydrated and documented that she needed a medical review. There is no evidence that Mrs B's burn wound was submerged in water or that water was poured over the burn to cool the wound, and instead a dry dressing was placed over the wound. RN E told Oceania:

> 'I remember her bed was positioned at the centre of the room then, later on during the incident happened, I have found her bed was already positioned by the window where the heater is located.'

30. RN E said that the carers informed her about the wound on Mrs B's leg at around 2am, and she did the dressing 'as per guidelines' and handed over to the morning nurse to call the GP or nurse practitioner. RN E did not specify which guidelines she followed when dressing Mrs B's burn wound.

31. The progress notes document that on the morning of 29 April 2022, RN F rang Nurse Practitioner (NP) D informing her of Mrs B's burn. NP D was not on site at Elmwood that day, and was covering Mrs B's usual GP, Dr G, who was away. NP D indicated that she would prescribe antibacterial cream for the wound. The progress notes contain no further details about the content of this phone call. RN F then informed RN C about Mrs B's burn injury, and RN C informed Mrs B's family about the burn. Ms A told HDC that they were told that Mrs B had sustained a burn injury but that it was 'minor'. The maintenance staff replaced the guard rails on Mrs B's room heater.

32. On 2 May 2022 the progress notes document that Mrs B's family were contacted over the phone, but there are no further details regarding the content of this phone call.

33. On 3 May 2022 the progress notes document that Mrs B verbalised pain from her burn wound. There is no evidence that a pain chart was commenced to monitor her pain relating to the burn injury.

34. On 4 May 2022 the progress notes document that Mrs B's granddaughter was contacted by phone, but there are no details regarding the content of the call.

35. On 4 May 2022 a wound swab was taken of Mrs B's burn injury, as the wound contained moderate yellowish discharge and appeared infected. Mrs B again complained of pain during the dressing, but a pain chart was not commenced.

36. On 5 May 2022 NP D was informed that a wound swab had been taken because Mrs B's burn injury appeared infected.

37. On 5 May 2022 the progress notes document that Mrs B's next of kin was contacted by phone and updated regarding Mrs B's wound treatment.

38. On 6 May 2022 the wound swab results showed a heavy growth of *Staphylococcus aureus*.[7] Elmwood staff contacted NP D, who prescribed Mrs B a seven-day course of oral flucloxacillin.[8] NP D told HDC:

> '[I] was first asked to provide treatment to [Mrs B] on 6 May 2022. On this day, [I] was not onsite but was called by the RN on duty who advised that [Mrs B's] wound was

[7] Bacteria frequently found on the skin.
[8] An antibiotic.

> looking infected. [I] noted that a wound swab that had arrived … on 4 May 2022 indicated that an infection was present, so [I] charted antibiotics for [Mrs B] as part of providing out of rounds support … [I noted that] it is common for skin infections to occur in older adults and normal for the nursing team to request antibiotics when a swab has been done, so [I] did not think much of this.'

39. The burn incident was then escalated to the management.

40. On 7 May 2022 the progress notes document that Mrs B was visited by her family, who asked to speak to a staff member regarding Mrs B's burn injury. This was scheduled for 9 May 2022.

41. On 9 May 2022 Mrs B's family had a family conference with RN C. The progress notes document that the family asked whether an investigation was being conducted as to how Mrs B had sustained the burn to her leg, and how her wound was being managed. RN C assured the family that an investigation was being conducted and that the wound was being monitored and assessed every day, a wound care plan had been created, antibiotics had been prescribed, and a wound nurse referral would be sent if the wound deteriorated.

42. On 10 May 2022 the progress notes document that Mrs B was visited by her family.

43. On 11 May 2022 a section 31 Sentinel Event Notification[9] was completed by Elmwood.

44. On 12 May 2022 the progress notes document that Mrs B was visited by her granddaughter.

45. On 13 May 2022 Mrs B received the last dose of her antibiotic and then another wound swab was taken.

46. On 13 May 2022 the progress notes document that Mrs B was visited by her family.

47. On 17 May 2022 a family meeting was held with Mrs B's granddaughters and senior staff. The burn injury and investigation outcome were discussed. Mrs B's granddaughters were shown a photo of the initial wound and the current wound and were noted to have been 'shocked' at the large size of the injury. The granddaughters asked for a copy of the investigation and a photo of the wound so that they could update their father.

48. On 17 May 2022 the progress notes document that Mrs B's burn wound was assessed by GP Dr G. The wound still appeared infected, as yellowish discharge was present. A referral to a plastic reconstructive service team was made, requesting advice for debridement[10] and grafting. Further oral flucloxacillin was recommended by the plastics team. The progress

[9] 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 or a situation that puts (or could potentially put) the health and safety of people at risk.
[10] Removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue.

notes document that following the consultation with Dr G, Mrs B's granddaughter was updated.

49. On 20 May 2022 the progress notes document that another family meeting was held, in which Mrs B's family decided to transfer Mrs B to hospital for further treatment, as it appeared that the wound infection was not resolving. Ms A told HDC that the family 'pushed' for Mrs B to go to a hospital for treatment.

50. On 21 May 2022 Mrs B was taken to a public hospital for wound debridement and grafting.

51. Oceania told HDC that Mrs B's wound was not assessed physically or seen by a GP or senior registered nurse for 20 days after the burn occurred. Oceania stated that this was because the nurses did not identify the severity of the burn and therefore did not consider that a review was necessary.

52. Mrs B returned to Elmwood on 31 May 2022. The discharge form from the hospital provided instructions on how to manage her wounds (graft wound and donor wound) going forward. Mrs B's graft wound was to be dressed with a special dressing and kept clean and dry, and her donor wound dressing from the hospital was to be left on until it hardened and then it could be removed, and the wound was to be kept clean and dry.

Policies and guidelines

First aid certification requirements — New Zealand Nurses Organisation

53. The New Zealand Nurses Organisation fosters professional accountability for qualified nurses by ensuring that nurses develop and maintain their professional knowledge and skills within their scope of practice. Its 'Accreditation manual for practice nurses'[11] notes that a registered nurse should have a First Aid certificate current within the previous two years.

Wound Management Policy (Issued June 2016, reviewed October 2023)

54. At the time of events, Elmwood had a Wound Management Policy, the purpose of which was to 'maximise healing, minimise pain and prevent cross infection …'.

55. The policy documents that wound management considers the resident's general health, diet, hydration, and pain as factors that can influence wound healing.

56. The policy notes that a wound assessment and wound management plan is required for wounds that require longer management due to factors such as pain, infection, etc.

Mrs B's pain management

57. Mrs B was able to express pain and discomfort.

[11] https://www.nzno.org.nz/Portals/0/publications/members/PN%20Accreditation%20Manual%20Oct%2007%20updated%20April%202009.pdf

58. Entries in Mrs B's progress notes that mention when she complained of pain to a registered nurse[12] are included in Appendix D. The table also notes when nurses used a pain scale to determine the level of pain Mrs B was experiencing, when she was given PRN (as required) pain relief,[13] and the effect of the pain relief on her pain.

59. Mrs B's expressions of pain were tracked over a one-month period, from 21 April 2022 until 21 May 2022 (see Appendix D). As reflected in the table, 20 entries mentioned when Mrs B complained of pain:

- Out of the 20 entries, only 6 entries noted that she was given pain relief.
- Out of the 6 times she was given pain relief, the effect of the pain relief was noted 6 times.
- Out of the 20 entries, only 5 entries noted how many times the pain scale was used to determine the level of her pain (from 0 = no pain, to 10 = severe pain).
- Out of the 20 entries, 11 related directly to her burn injury and pain during wound dressings.
- Out of the 11 entries, none noted a pain scale.
- Out of the 11 entries, no PRN pain relief was given to Mrs B.

60. A pain chart documents details of where the pain is in a resident's body, how the nurse assessed the resident to be in pain, the description of the pain, the pain score, intervention, effectiveness of intervention, and the author and their role.

61. A pain chart was started on Mrs B's admission on 20 April 2022 and continued for two days. A month later, on 20 May 2022, a new pain chart was commenced, but the next day Mrs B was admitted to hospital. This pain chart recommenced when Mrs B returned from hospital on 31 May 2022 following the surgery on her burn wound.

62. There is no evidence that a short-term care plan was developed for Mrs B to direct staff in how to manage her pain after she sustained the burn injury and during wound dressings.

63. Oceania told HDC that clinical staff fell short of expected practice regarding pain monitoring. Oceania noted that on 3 May 2022 staff recognised that Mrs B required additional pain medication, but a pain monitoring chart was not commenced to guide cares. Notwithstanding this, Oceania maintained that Mrs B received pain relief from 3 May onwards. However, as noted in the table at Appendix D, out of 11 entries where Mrs B complained of pain relating to her burn injury between 21 April 2022 and 21 May 2022, no PRN pain relief was recorded as being given. Oceania stated: '[T]here needs to be

[12] Registered nurse entries were recorded, as it is within their scope to be give pain relief based on their assessment of a person's pain.
[13] Mrs B was on regular pain relief, but when she experienced pain outside these times and needed PRN pain relief (such as during wound dressings), this data was recorded instead.

improvement in recording on the pain monitoring tool so that it is easier to review, rather than in progress notes entries.'

Management during staffing constraints

64. Oceania told HDC that at the time of Mrs B's injury, Elmwood was in a second COVID-19 lockdown with several staff off sick and other staff taking extra shifts. The afternoon carers working on 28 April 2022 worked long shifts to cover staff absences, completing their shifts at 11.15pm. Oceania maintained that 'low staffing levels contributed to care staff missing the regular time to turn [Mrs B], which contributed to the burn injury'.

65. RN C told HDC that he worked in the rest-home wing, while his colleague worked in the hospital side, where Mrs B resided. RN C told HDC that on 29 April 2022 he was asked to assist RN F, in the hospital side to 'ensure everything [had been] done'.

66. RN F told HDC that she was working in the hospital wing where Mrs B was admitted. On 29 April 2022 she was asked to work in Elmwood for 4–5 hours to assist RN C, as other staff members were on leave. RN F stated: '[As I was] not yet fully trained to step up [into a senior role] … during this time, I was waiting for instruction from [RN C] on what to do next.'

Sentinel Event Root Cause Analysis investigation

67. On 9 June 2022 Oceania completed a Sentinel Event Root Cause Analysis report, which noted that the following root causes contributed to Mrs B's burn injury incident:

a) The uncovered heater next to the bed was not identified.

b) The heater guard was not in place.

c) Mrs B was not checked and turned two- to three-hourly as per her care plan.

68. A care plan regarding pressure injury management that noted 'two–three hourly' turns was not sighted in Mrs B's documentation from Oceania.

69. The Sentinel Event Root Cause Analysis report noted that all staff involved in Mrs B's burn incident 'lacked awareness of the health and safety procedures specifically hazard identification … They did not recognise the danger of having the bed next to the unguarded heater.' The report also documented that Mrs B's wound was not assessed physically by a senior registered nurse, nurse practitioner, or GP until 20 days post her burn incident.

Further information

70. Oceania told HDC:

> '[We] acknowledge the substantial extent of the injury and the significant impact this has had on [Mrs B] and her family's well-being. We accept that on this occasion we did not provide our usual high standard of resident-centred care, and we sincerely regret this.'

Responses to provisional opinion

Oceania Care Company Limited (trading as Elmwood Village)

71. Oceania Care Company was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. Oceania's comments have been incorporated into this report where relevant.

72. Oceania stated: 'We do not dispute any of the information gathered during the investigation, and the preliminary conclusions that you have drawn based on that information.' It added:

> 'We accept that the specific issues with the standard of care provided to [Mrs B] are the result of poor adherence to policies and procedures by multiple staff, and inadequate systems in place at Elmwood. We take overall responsibility for the deficiencies in the care provided to [Mrs B]. We accept that these are attributed to systemic issues that we are in the process of addressing.'

73. Oceania stated:

> '[We are] deeply sorry that we did not provide [Mrs B] with an appropriate standard of care between April and May 2022 and that our communication with the family during this time and during our internal investigation was not satisfactory.'

RN C

74. RN C was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. However, HDC did not receive a response.

NP D

75. NP D was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. However, Oceania Care Company told HDC that NP D declined to provide a response.

RN E

76. RN E was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. However, Oceania Care Company told HDC that RN E declined to provide a response.

Ms A

77. Ms A was given the opportunity to respond to the 'information gathered' section of the provisional opinion.

78. Ms A told HDC that reading through the provisional opinion 'brought up an overwhelming wave of pain and sadness' for what their grandmother, Mrs B, endured during her time at Elmwood Village. Ms A stated: '[The family are] devastated and furious about the horrific negligence our grandmother suffered at Elmwood Village.' She noted: '[It] was not simply a failure in care — it was systemic, preventable harm that left [Mrs B] in pain, untreated, and completely dehumanised.'

79. Ms A outlined her family's key concerns after reading the provisional opinion:

- *'Failure to complete critical assessments upon admission'*

On reading that only the dietary assessment was completed out of 13 admission assessments, Ms A noted that it is 'more evident that [their] grandmother did not receive proper care upon admission'.

- *'COVID-19 cannot excuse this level of negligence'*

Ms A stated: 'The pandemic may have put pressure on operations, but it is not and will never be an excuse to abandon fundamental duties like ensuring a patient is safe in her bed. Our grandmother was left lying for hours with her skin pressed against a hot, unguarded heater, sustaining severe second-degree burns.' Ms A said that this is unforgivable. She recalled: '[Mrs B] later described the smell of her own burning flesh — an image that will haunt our family forever and causes us extreme emotional trauma.'

- *'Inappropriate and inadequate wound treatment'*

Ms A was concerned about the lack of burn-specific first aid provided to Mrs B.

- *'Delay in medical review & declining health'*

Ms A stated: 'It is unthinkable that the wound was not physically assessed by a senior nurse, GP, or nurse practitioner for twenty days. It is hurtful for us to confirm that no one thought her injury was significant enough to require immediate medical attention … Our grandmother was already in a fragile state and did not need to undergo an extreme skin graft surgery at her old age. We believe this injury contributed significantly towards her declining health …'

- *'Lack of transparency and misleading communication'*

Ms A stated: 'It took multiple requests before we were finally shown the true extent of her injury. This delay in transparency is, to us, clear evidence that the staff knew how bad the injury really was and were trying to downplay it.'

- *'Profound cultural and emotional impact.'*

Ms A told HDC: 'In our culture, caring for elders ourselves is the norm. Placing our grandmother in a care home was a heartbreaking decision made out of necessity after her stroke. To now know she was neglected upon admission and burned while in their care — and left in pain for weeks — has caused indescribable pain to our family [and] [a]dmitting our grandmother to Elmwood is something we deeply regret every single day … This was our grandmother — the woman who raised us, loved us unconditionally, and showed us endless kindness throughout our lives. She was the sweetest soul we have ever known, and even these words fail to capture how much she meant to us.'

Opinion: Oceania Care Company Limited (trading as Elmwood Village) — breach

80. I acknowledge the distress that this event has caused Mrs B's family. I understand that Mrs B has since passed away, and I offer my condolences to her family for the loss of their loved one. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Elmwood was appropriate, I considered in-house nursing advice from RN Johnson-Bogaerts (Appendix A).

81. In considering the information received, I have noted that the issues with the standard of care provided to Mrs B are the result of poor adherence to policies and procedures by multiple staff, and inadequate systems in place at Elmwood. Accordingly, I have attributed the deficiencies in the care provided to Mrs B to Oceania, who had overall responsibility at a service level.

Mrs B's admission to Elmwood Village

82. Mrs B was admitted to Elmwood Village with a complex medical background and a high level of needs due to a recent stroke. Mrs B required hospital-level care.

83. Oceania told HDC that several of Mrs B's assessments were completed on admission, such as a pain assessment, pressure injury assessment, skin assessment, and a mobility and transfers assessment. However, on review of the documentation received from Oceania, only one assessment out of 13 had been completed for Mrs B on her admission.

84. RN Johnson-Bogaerts advised:

> 'At the time of admission registered nurses complete a comprehensive set of assessments and create an interim care plan to guide care staff for the first few days and until a comprehensive long term care plan is developed. In residential aged care, care plans serve as essential tools for ensuring coordinated and comprehensive care regardless of which team member is on duty, maintaining high quality and holistic care and meeting the resident's needs as they evolve. By involving the resident and their families in the care planning process, care plans ensure that the care provided aligns with their wishes and expectations.'

85. The ARRC agreement notes that 'each Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 21 days', which aligns with RN Johnson-Bogaerts' advice.

86. Oceania told HDC that no interim care plan was completed for Mrs B on her admission, and therefore staff were not guided to complete the required monitoring.

87. RN Johnson-Bogaerts advised that because Mrs B's admission assessments were not completed, no information was available to inform an interim care plan for Mrs B to guide staff in how to manage her appropriately given her high level of needs due to her stroke.

RN Johnson-Bogaerts considers that this amounted to a moderate to significant departure from the accepted standard of care.

88. I accept RN Johnson-Bogaerts' advice.

89. I have considered the relevant policy in place at the time of events. Oceania's Person-Centred Care Planning Policy documented that 'comprehensive' care plans were to be developed based on 'thorough' assessments of the resident's needs. This policy also noted that an interim care plan was to be completed within 24 hours of a resident's admission.

90. I consider that assessments and care planning are an essential cornerstone of good nursing practice. I am critical that these were not developed for Mrs B, thereby contributing to inconsistent delivery of personalised care across shifts, and an increase in the risk of essential care being missed, including Mrs B's environmental safety and management of her risk of falling from bed.

91. As noted above, assessments were not completed for Mrs B on admission to Elmwood, and therefore interim care plans could not be developed, and staff were not guided to complete the required monitoring for Mrs B.

92. Mrs B was assessed by a physiotherapist, who documented recommended care such as using a full hoist to transfer Mrs B.

93. RN Johnson-Bogaerts advised that the physiotherapist's assessments provided no specific instructions on how to prevent Mrs B's risk of falling while she was in bed, such as ensuring that her bed was in a low position to the floor. Oceania told HDC that for some residents, beds were routinely moved against the wall in order to place a sensor mat by the bed.

94. RN Johnson-Bogaerts advised:

> 'Putting one side of the bed against the wall can provide security to residents and is often the preference of some residents. I did not find in the notes any reference that this was discussed with [Mrs B], that this was according to her preference, or needed for safety reasons. The practice of pushing a resident's bed against a wall with a heater is not standard practice and would be inappropriate in most circumstances. It would seem that staff positioned [Mrs B] too close to the edge of the bed [and] her left leg slipped off and close enough to the heater to sustain a large second degree burn on the left lateral side of her left knee.'

95. RN Johnson-Bogaerts advised that as part of preventing falls, 'it is standard practice for care staff to ensure the environment is safe for residents at all times, especially for those residents with limited mobility and who are fully dependent on staff assistance mobilising [as Mrs B was]'.

96. RN Johnson-Bogaerts said that because no falls risk assessment was completed (given Mrs B's dense left-sided weakness due to a stroke), the care plan contained no guidance on keeping Mrs B safe from falling, and although she was assessed by physiotherapists, no

specific instructions were provided to staff on how to prevent Mrs B from falling from the bed. RN Johnson-Bogaerts considers that this amounted to a significant departure from the accepted standard of care.

97. I accept RN Johnson-Bogaerts' advice.

98. Oceania told HDC that residents' beds are 'routinely moved against the wall for a few residents' as a fall prevention strategy. However, Oceania also told HDC that '[staff] lacked awareness of the health and safety procedures specifically hazard identification and … [t]hey did not recognise the danger of having the bed next to the unguarded heater'.

99. In my opinion, the absence of assessments and a care plan on admission contributed to staff being unaware of how to manage Mrs B's care safely and appropriately. I am concerned that staff appeared to lack awareness of the potential health and safety concerns, not only for a resident with her paralysed side being next to a heater, but also the fire hazard created by having her bedsheets against the heater. Staff also failed to recognise that the heater was unguarded, which was another environmental hazard.

Pressure-injury prevention

100. RN Johnson-Bogaerts advised:

> 'A pressure injury is localised damage to skin and underlying tissue caused by pressure, friction or shearing forces. It can develop when pressure temporarily cuts off circulation and tissue dies. A pressure injury prevention plan should be developed for residents at risk. Such plan typically includes interventions such as supporting the resident to move, turn, and reposition every two hours. To ensure continuation of care, observations and actions are documented on a repositioning chart.'

101. An assessment by a physiotherapist documented that Mrs B was for 'regular' turns/repositioning given her dense weakness on the left side of her body due to a stroke.

102. Oceania told HDC that Mrs B's progress notes document that staff were providing pressure-injury preventative care. However, Oceania said that 'it is unknown if this was carried out two hourly as no pressure care charting was started over this period'.

103. Mrs B's pressure-area management entries in the progress notes were tracked over a one-month period. This showed that out of 49 entries, only 12 noted the frequency of her turns (such as hourly or every two hours), and only 7 entries noted which side of her body she was turned to.

104. RN Johnson-Bogaerts advised that the lack of staff recording of Mrs B's turns on a dedicated chart in order to provide consistent care, and the inconsistent recording of the frequency of Mrs B's turns and which side of her body she was turned/repositioned on to, amounted to a significant departure from the accepted standard of care.

105. I accept RN Johnson-Bogaerts' advice.

106. I have considered the relevant policies in place at the time of events. Oceania's Pressure Injury Risk Management and Skin Care policy documented that a pressure-injury assessment, monitoring form, and care plan was to be developed. I am critical that Mrs B's pressure-injury assessment was not completed on admission, and that therefore a specific care plan was not developed to guide staff.

107. Given that Mrs B was paralysed on her left side and required two staff to reposition her, I am critical that this care was not prioritised and documented on a dedicated turns/ repositioning chart in order to track how often she was repositioned and when her next turn was due, so that this essential care was not missed. In addition, as these turns were not recorded on a dedicated chart consistently, staff did not identify that Mrs B had been left for five to six hours, and that during this time her leg had slipped against the unguarded heater.

Sentinel event 28 April 2022 — management of Mrs B's burn injury

First aid treatment

108. At around 8.00pm on 28 April 2022 Mrs B was in bed, with her bed pushed against the wall panel heater. Although Mrs B required regular two-hourly turns because of paralysis on her left side, it was not until 1.30am on 29 April 2022 (approximately five hours later) that her paralysed left leg was found to have slipped down between the heater and the bed, and that she had sustained a large second-degree burn to her leg.

109. RN Johnson-Bogaerts advised:

> 'I did not find documentation of first aid treatment of the burn such as cooling the area under streaming cold water. [Due to] the size of the burn it would have been recommended for the RN to have initiated moving [Mrs B] to the shower where the side of her leg could have been cooled under running water. This type of first aid can reduce the risk of complications such as infection and deeper tissue damage.'

110. It is documented that instead, the nurse who treated Mrs B initially, RN E, placed a dry dressing over the wound. Given the lack of evidence of cooling cares, I consider it more likely than not that cooling was not undertaken.

111. RN Johnson-Bogaerts considers that the lack of cooling care as first aid treatment of a burn injury was a failure to adhere to basic and well-established first aid protocols. RN Johnson-Bogaerts advised that this amounted to a moderate departure from the accepted standard of care.

112. Whilst this was an individual action (discussed below), it further illustrates the pattern of staff not following basic guidelines and links to the multiple failures to manage Mrs B's wound adequately.

113. I have also considered the relevant policy in place at the time of events. Oceania's Wound Management Policy documented that a wound management plan was to be created to track

the management of the wound. I am critical that this was not done for Mrs B to guide staff on how to manage Mrs B's wound.

Escalation for medical review

114. RN Johnson-Bogaerts advised:

> 'Given [Mrs B's] co-morbidities and the fact that the wound resulted from an accident at the care home, it would have been prudent for the RN on duty at an earlier date to have escalated the wound for medical review … [It also] would have been better if the RN [had] used the SBAR (Situation, Background, Assessment, Recommendation) tool to communicate a completer picture of the issue, including a photo of the wound … This approach would ensure that all necessary information is considered, leading to more informed and effective clinical decisions.'

115. Oceania told HDC that Mrs B's wound was not assessed physically or seen by a GP or senior registered nurse for 20 days after the burn occurred, because the nurses did not identify that it was a severe burn that required an urgent review.

116. I consider that from 29 April 2022 to 21 May 2022 there were several instances in which a GP review was required. For example, on 3 May 2022 Mrs B started to indicate that she was in pain when her wound was redressed, and on 4 May 2022 the burn appeared to be infected, and Mrs B required antibiotics.

117. On 17 May 2022 the wound again appeared infected with yellowish discharge, and further antibiotics were prescribed. It was not until 20 May 2022 that it was decided that Mrs B needed to go to hospital for further burn injury treatment. Ms A told HDC that they had to 'push' for Mrs B to go to the hospital for treatment.

118. Taking the above into account, RN Johnson-Bogaerts advised that it appears that the nurses did not identify that the injury was significant, and this resulted in a delay in escalating Mrs B's care to the GP and 'substandard' communication with the nurse practitioner, which further delayed an in-person review of Mrs B. RN Johnson-Bogaerts advised that this amounted to a moderate to significant departure from the accepted standard of care.

119. I accept RN Johnson-Bogaerts' advice.

120. I am concerned that Ms A said that the family had to 'push' for Mrs B to go to hospital, and that Oceania told HDC that Mrs B's wound was not reviewed by the GP for 20 days. This illustrates that staff appear not to have recognised the severity of Mrs B's wound and did not escalate her care to the GP in a timely manner, by which time the wound was infected and Mrs B required surgery.

Mrs B's pain management

121. Over a one-month period from 21 April 2022 to 21 May 2022, 20 entries recorded that Mrs B complained of pain. Out of these 20 entries, 11 related directly to her burn injury and pain during dressing changes. However, there is no documented evidence that Mrs B

received any PRN pain relief to help ease her discomfort during the wound dressings in all 11 instances.

122. Mrs B first complained of pain during her wound dressing on 3 May 2022, but it was not until 17 days later, on 20 May 2022, that a pain chart was started to document details of Mrs B's expressions of pain. Mrs B was admitted to hospital the following day (21 May 2022) for treatment of her burn injury.

123. I also note that although Mrs B expressed pain during her wound dressings, no short-term care plan was created to direct staff in how to manage her discomfort appropriately during these times.

124. RN Johnson-Bogaerts advised:

> 'Pain assessment and management are crucial, especially for residents with complex health needs like [Mrs B]. The standard of care involves regular, comprehensive pain assessments using validated tools appropriate for the resident's communication abilities, such as the Numeric Rating Scale (NRS), the Visual Analog Scale (VAS), or the Abbey Pain Scale for those with cognitive impairments.'

125. RN Johnson-Bogaerts noted:

> 'All pain assessments should be documented, including intensity, location, and any non-verbal cues, especially for residents who have difficulty communicating. An individualized Pain Management Plan should be developed, incorporating both pharmacological (e.g., analgesics, anti-inflammatories) and non-pharmacological (e.g., physical therapy, relaxation techniques) interventions. Pain relief measures should be administered promptly, and their effectiveness evaluated.'

126. RN Johnson-Bogaerts advised that the lack of an appropriate short-term care plan for Mrs B's pain management and the incomplete pain assessments amounted to a moderate departure from the accepted standard of care.

127. I accept RN Johnson-Bogaerts advice.

128. Oceania acknowledged that pain monitoring fell short of its expected practice, and that Mrs B's expressions of pain needed to be recorded on a separate document, as 'it is easier to review, rather than in progress notes entries'. However, I remain critical of the inaction of various nurses who noted that Mrs B was in pain during her dressing changes but did not develop a short-term care plan to direct staff to administer Mrs B pain relief prior to dressing changes. There is no documented evidence that PRN pain medication was provided, and it is likely that Mrs B had to endure painful dressing changes.

129. I am also concerned that a pain chart was not commenced earlier, as the next day Mrs B was admitted to hospital. A pain chart should have been started when Mrs B first expressed pain related to her wound dressings, so that a care plan could be developed to manage her pain better during her dressings.

Management during staffing constraints

130. The Root Cause Analysis report identified that during the time Mrs B sustained her burn injury, 'several staff [were] off sick, and nurses and HCAs were picking up extra shifts to cover the roster. … '

131. RN Johnson-Bogaerts advised:

> '[I] acknowledge the staffing challenges but still expect contingency plans to be in place that prioritise the most vulnerable and dependent on nursing input. [T]here was no such contingency plan for staff on the day supporting them on how they could prioritise their care tasks …'

132. RN Johnson-Bogaerts advised that Elmwood's lack of a contingency plan to prioritise vulnerable residents during staff shortages amounted to a moderate departure from the accepted standard of care.

133. I accept RN Johnson-Bogaerts' advice. Prioritising care to the most vulnerable and dependent residents is of the upmost importance, especially in times of staffing shortages. RN Johnson-Bogaerts also advised that on the night the burn occurred, Elmwood was not understaffed. I am concerned that despite adequate staffing levels, Mrs B's regular turns were missed for an extended period, during which she sustained the severe burn.

Conclusion

134. In summary, I find that Oceania Care Company Limited (trading as Elmwood Village) did not provide Mrs B with an appropriate standard of care in April to May 2022. I consider that the issues represent a pattern of poor care and non-compliance with policies, for which ultimately Oceania is responsible. Oceania is responsible for ensuring that all staff are aware of, and follow, its policies. Given that multiple staff failed to follow Oceania's policies, I consider this to be a systemic issue attributable to Oceania.

135. Accordingly, I find that Oceania Care Company Limited (trading as Elmwood Village) breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[14] for the following reasons:

a) Incomplete admission assessments contributed to a lack of comprehensive care planning and of short-term care plans for Mrs B.

b) The lack of essential wound documentation, such as a wound management care plan, meant that Mrs B's specific wound care needs in relation to her burn injury were not identified, and no short-term care plan was created to guide staff.

c) The lack of essential pain management documentation meant that when Mrs B expressed pain in relation to her wound dressings, her pain relief needs were not identified consistently and appropriate pain relief given to make her more comfortable.

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

d) When Mrs B was first discovered to have sustained a second-degree burn wound, no cooling care was initiated as part of the first aid response.

e) No contingency plans were developed to manage staff shortages, which meant that vulnerable residents like Mrs B were not prioritised to ensure that their essential needs were met. As a result, Mrs B was not repositioned for over five hours, and she sustained a severe second-degree burn to her leg.

136. In addition, I find that Oceania Care Company Limited (trading as Elmwood Village) breached Right 4(4) [15] of the Code for failing to provide Mrs B with services in a manner that minimised potential harm to her and optimised her quality of life, for the following reasons:

a) A falls risk assessment was not completed for Mrs B, given her presentation with a stroke, and therefore a care plan was not developed to guide staff on how to prevent Mrs B from falling from her bed.

b) Staff lacked awareness of health and safety procedures to identify potential hazards and harm to consumers.

c) Mrs B's bed was placed against a wall heater without a guard inappropriately, which presented a risk of physical harm and fire.

d) No dedicated turns/repositioning chart was commenced for Mrs B to document when she was repositioned, and to which side of her body, to ensure that she was repositioned regularly for her own comfort and to decrease the risk of pressure injuries developing.

e) Appropriate first aid was not given to minimise the complications of the burn.

Individual providers

137. The Sentinel Event Root Cause Analysis report documented that Mrs B's burn wound was not assessed physically by a senior registered nurse or the nurse practitioner until 20 days post her burn incident.

138. It was identified that on the day of the incident, the senior staff member was RN C. However, RN C told HDC that RN F was the senior staff member. There is conflicting information from both RN C and RN F as to who was the senior staff member at this time, and no clarification has been provided by Oceania.

139. The nurse practitioner at the time of the incident was NP D.

RN C — educational comment

140. RN C told HDC that he was in charge of the rest-home wing of Elmwood. RN C stated:

[15] Right 4(4) stipulates that '[e]very consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer'.

> '[A]n acting [senior staff member, RN F was] assigned in [Mrs B's] area during the incident. I was asked by … to assist the … to ensure everything [had been] done [and] report back to her.'

141. Conversely, RN F stated that during the time of events she was 'not yet fully trained to step up … ', and she was asked to work at Elmwood for a few hours on 29 April 2022 to assist RN C, and she took instruction from him on this day.

142. RN Johnson-Bogaerts advised:

> 'The role of the [senior staff member] is crucial in ensuring the quality of care. The identified issues suggest there might have been a lapse in clinical oversight. It is important for the [senior staff member] or the RN in charge to ensure that all staff consistently adhere to Oceania's Policies and Procedures, especially in light of the issues identified above. A key aspect of effective clinical leadership is promptly identifying, reviewing, and following up on all incidents.'

143. I accept RN Johnson-Bogaerts' advice. In my opinion, RN C was the most experienced leader at this time and was tasked with assisting RN F on this day. Therefore, he held some responsibility for ensuring that staff responded to the incident appropriately.

NP D — educational comment

144. NP D stated:

> 'The nursing team is tasked with organising and facilitating [which resident] gets reviewed during the two clinical rounds per week. The team does this by preparing a consultation register, with the names and concerns of patients, which is then triaged so acute patients are seen first … Consequently [I rely] on the nursing team to assess and identify care needs of the resident and determine who needs to be reviewed.'

145. RN Johnson-Bogaerts advised:

> 'It would be my recommendation for [NP D] to insist on receiving a more complete clinical [picture], ideally in a written format of SBAR and accompanied by relevant pictures before agreeing to prescribe antibiotics.'

146. In my opinion, it appears that the nursing staff were not aware of the severity of Mrs B's burn injury, and therefore the nurse did not convey the urgency of Mrs B's situation as part of a fulsome report to NP D. Consequently, NP D did not prioritise and triage Mrs B for an urgent review.

147. I agree with RN Johnson-Bogaerts that it would be of benefit for NP D to insist on a more fulsome report from the nursing staff, especially if she is not working on site, so that she is better able to prioritise medical reviews. However, I acknowledge that NP D was making decisions based on the information provided to her by Elmwood, and she did not review Mrs B physically.

RN E — adverse comment

148. RN Johnson-Bogaerts advised:

> 'I did not find documentation of first aid treatment of the burn such as cooling the area under streaming cold water. [Due to] the size of the burn it would have been recommended for the RN to have initiated moving [Mrs B] to the shower where the side of her leg could have been cooled under running water. This type of first aid can reduce the risk of complications such as infection and deeper tissue damage.'

149. It is documented that the nurse who treated Mrs B initially, RN E, instead placed a dry dressing over the wound. Given the lack of evidence of cooling cares, I consider it more likely than not that these were not performed.

150. RN Johnson-Bogaerts advised that the lack of cooling care given as first aid treatment of a burn injury was a failure by the nurse to adhere to basic and well-established first aid protocols, and this amounted to a moderate departure from the accepted standard of care.

151. I accept RN Johnson-Bogaerts' advice. I am critical that RN E did not initiate basic first aid treatment by providing cooling care to Mrs B's burn wound to prevent worsening of the wound. This also may have provided some relief to Mrs B.

Changes made since events

152. Oceania told HDC that as part of an improvement project to ensure that resident-specific care needs are assessed and documented fully, clinical managers and registered nurses have undertaken assessment and care planning training (completed in December 2023).

153. Oceania said that post investigation it was highlighted that there were no specific maintenance checklists for resident rooms ready for occupancy post repairs. This has since been rectified, and the maintenance checking schedule now covers checking that all heater guards are in place post room renovation.

154. Clinical staff education on burn management, escalation, and the STOPANDWATCH communication tool has been completed with staff at Elmwood.

155. All corrective actions highlighted in the initial Sentinel Event Root Cause Analysis investigation plan have been completed. These actions included education to staff on hazard identification and health and safety awareness; a heater guard installed in Mrs B's room and all wall heaters reviewed to ensure that guards are in place and a checklist for room readiness developed; ensuring that repositioning charts are in place for residents who require them, providing education to staff regarding the importance of checking and turning residents, and undertaking quarterly audits to check that repositioning charts are completed; providing education to registered nurses regarding wound assessments, especially burn injuries assessment and treatment.

156. In response to the provisional opinion, Oceania also noted the following changes:

- Oceania introduced a 'flexible' roster that ensures that there is a good skill mix and distribution of clinical expertise across all shifts.
- There is a regional pool of clinical staff who can work and cover unplanned short-notice leave.
- Oceania renewed the Infection Prevention and Control policy as well as escalation plans, which offer an increased level of support to its sites during an outbreak.
- Elmwood Care Centre has two designated nursing practitioners who are on site 3–4 days a week, providing a primary-care service.
- There is an increased awareness of Health and Safety across all Oceania's sites, and hazards are identified early.
- Since early 2023, there has been a focus on developing clinical leadership and accountability in its teams. Oceania introduced a project 'Gemba Walks' across its care centres where staff and residents are observed (and interacted with) in their actual work environment by clinical managers daily and by regional and executive team members monthly. Oceania stated that this project fostered a deeper understanding of the daily operations of its teams.
- Oceania has developed an Early Warning and High-Risk Facility profiling system to proactively identify risk and ensure that mitigation strategies are in place to safeguard residents.

Recommendations

157. I recommend that Oceania Care Company Limited (trading as Elmwood Village) undertake the following, within three months of the date of this report:

a) Develop robust contingency plans for staffing shortages and ensure that staff are supported adequately during such times, with clear written and verbal instructions and the ability to prioritise the most vulnerable residents. An example of this contingency plan is to be sent to HDC.

b) Review the education/training being provided to staff in relation to managing a resident's pain, especially if they have had a stroke and have difficulty verbalising their pain (either in relation to the stroke, or other medical condition, or when their primary language is not English); ensure that appropriate assessments (such as the pain scale) are used consistently, and that pain relief is administered as needed, with these interventions being documented appropriately; and ensure that short-term pain management care plans are developed promptly. Please provide HDC with evidence of the education/training in the form of education/training material and staff attendance records.

c) Review the education/training being provided to staff in relation to first aid management of burn wounds (in particular, ensuring that wound management care plans are created when needed) and provide HDC with evidence of the education/training in the form of education/training material and staff attendance.

d) Use an anonymised version of this report as the basis for future training in its other care homes across New Zealand.

158. I recommend that Oceania Care Company Limited (trading as Elmwood Village) provide a written apology to Mrs B's family for the issues identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

Follow-up actions

159. Oceania Care Company Limited (trading as Elmwood Village) 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.

160. A copy of this report with details identifying the parties removed, except the advisor on this case and Oceania Care Company Limited (trading as Elmwood Village), will be sent to HealthCERT and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RN Johnson-Bogaerts:

> '1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Elwood Village (EV). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> 2. **Complaint**
> At the time of the events, [Mrs B] was an 85 year old lady who moved into care at Elmwood Village (EV) on 20 April 2022 to receive hospital level care following a stroke. As a result of the stroke [Mrs B] experienced significant left sided weakness, inability to maintain her posture, and needing full support with all activities of daily living, and with mobilising (including bed mobility). As a result of this she also needed pressure injury prevention cares such as regular repositioning. … [Mrs B] was able to express pain and discomfort.
>
> The complaint centers on the care provided to [Mrs B] on 28 and 29 April 2022 when it was discovered she sustained a burn on her leg due to her bed being pushed against a wall heater without a heat guard. [Mrs B's] leg slipped between the heater and the bed, resulting in a second-degree burn.
>
> 3. I am asked to review the information on file and provide clinical advice on the following aspects of nursing care provided to [Mrs B] at EV at the time of the incident:
>
> - ***Falls Management:*** *The a*ssessment of [Mrs B's] mobility and fall risk and the appropriateness of pushing [Mrs B's] bed against a wall with a heater.
> - ***Care Planning:*** The completion and appropriateness of care plans, assessments, progress notes, and turning charts.
> - ***Turn/Repositioning Charts and Hourly Visual Checks:*** The assessment of [Mrs B's] need for regular repositioning and the impact of the lack of recorded hourly visual checks on [Mrs B's] care.
> - ***Escalation of Burn Injury***: The timeliness and appropriateness of the escalation of [Mrs B's] burn injury to appropriate personnel (RN, NP, GP). The evaluation of steps taken to manage the burn injury.
> - ***Staffing Constraints and COVID-19:*** The impact of staffing constraints on the standard of care provided and Elmwood's procedures for covering shifts and managing staffing deficits during this time.
> - ***Policies and Staff Education***: The adherence to policies and procedures in place at the time of the event.
> - ***Management of Pain:*** The assessment of the adequacy and appropriateness of [Mrs B's] pain management (April to May 2022). Evaluation of documented evidence of pain management practices.
> - **Clinical oversight**

4. Documents reviewed

- Provider's response dated 12 December 2022, 13 December 2023, and 15 February 2024
- Wound Care Plan (1 June 2022)
- Progress notes
- Personal Hygiene and Care Monitoring Charts
- Root Cause Analysis
- Incident Accident Reports
- Policies and procedures in place from April to May 2022 i.e. Pressure Injury Risk Management and Skin Care Policy, Person Centred Care Planning Policy
- MediMap/med chart for April to May 2022
- Wound Chart
- Staff Rosters
- Response [NP D] dated 9 February 2024

5. Review documentation and clinical advice

Falls Management:

***Standard of care*:** When moving into a care home it is standard practice for the nurses to complete a falls risk assessment, mobility and transfer assessment and use this information to develop a care plan relating to mobilising and falls prevention. For complex mobility issues such as these of [Mrs B] it is good practice to involve a physiotherapist in the assessment and care planning. As part of falls prevention it is standard practice for care staff to ensure the environment is safe for residents at all times, especially for those residents with limited mobility and who are fully dependent on staff assistance mobilising.

***Review of documentation*:** The provider response included that "*Contrary to our standard practice, no initial care plan or interim care plan was started on [Mrs B's] admission. However, assessments were completed at the time of the admission …*" and that the progress notes instead were guiding staff.

The progress notes include a physiotherapist assessment and recommendations entered on 21 April and 22 April 2022 showing [Mrs B] needed to be transferred with full body hoist to use a fall out chair allowing to modify her posture, for bed mobility she needed assistance from 2 care staff for repositioning. The care notes include that staff would reposition/turn [Mrs B] regularly using the slide sheet as directed by the physiotherapist.

No specific instruction or references were found in the notes relating to falls risk while [Mrs B] was in bed such as lowering the bed etc. Given [Mrs B's] full dependency for mobility due to her left sided hemiplegia, it is implied that care staff should take extra precautions when turning and repositioning her.

The provider response states that on 28 April 2022 care staff who completed the evening cares and assisted [Mrs B] into bed at around 20.00hrs moved her bed against the wall so that she would not roll off the bed during the night. They did not notice that there was no heater guard on the heater and that the bed lay directly next to the heater.

Putting one side of the bed against the wall can provide security to residents and is often the preference of some residents. I did not find in the notes any reference that this was discussed with [Mrs B], that this was according to her preference, or needed for safety reasons. The practice of pushing a resident's bed against a wall with a heater is not standard practice and would be inappropriate in most circumstances. It would seem that staff positioned [Mrs B] too close to the edge of the bed seeing as her left leg slipped off and close enough to the heater to sustain a large second degree burn on the left lateral side of her left knee (14cm x 3cm).

Departure from accepted practice: Positioning [Mrs B's] bed against the wall with an unguarded heater, represents a significant departure from accepted practice. It would seem staff failed to recognise the hazard such heater posed especially without the guard attached. This would be viewed by peers as a serious oversight.

Care Planning:

Standard of care: At the time of admission registered nurses complete a comprehensive set of assessments and create an interim care plan to guide care staff for the first few days and until a comprehensive long term care plan is developed.

In residential aged care, care plans serve as essential tools for ensuring coordinated and comprehensive care regardless of which team member is on duty, maintaining high quality and holistic care and meeting the resident's needs as they evolve. By involving the resident and their families in the care planning process, care plans ensure that the care provided aligns with their wishes and expectations.

Review of documentation: The provider response includes that although a majority of assessments were completed for [Mrs B] "*there were no completed care plans for [Mrs B], Health Care Assistants (HCAs) were not guided to complete the required monitoring for [Mrs B]".* Instead care staff were guided by the progress notes. This was in breach of the organisation's Person Centred Care Planning Policy.

I note that [Mrs B] had complex care needs and was at high risk for developing pressure injuries. She needed pressure relief equipment and regular repositioning. The progress notes include instructions from the physiotherapist for transfer and seating. I did however not find specific instructions relating to pressure relief equipment or frequency of repositioning needed while in bed. The progress notes include that staff provide assistance with food and with hygiene cares, assess for pain and comfort, and were repositioning [Mrs B]. Frequency of repositioning was not noted.

Departure from accepted practice: Not having the initial and ongoing care plans in place is concerning and in breach of the organisation's policy and would be seen by my peers

as poor nursing practice. In the circumstances and taking into account [Mrs B's] complex care needs I consider this to have been a moderate to significant departure from accepted practice.

Turn/Repositioning Charts and Hourly Visual Checks:

Standard of care: A pressure injury is localised damage to skin and underlying tissue caused by pressure, friction or shearing forces. It can develop when pressure temporarily cuts off circulation and tissue dies. A pressure injury prevention plan should be developed for residents at risk. Such plan typically includes interventions such as supporting the resident to move, turn, and reposition every two hours. To ensure continuation of care, observations and actions are documented on a repositioning chart. During the night the frequency of repositioning can be reduced if the person is supported by a pressure relief mattress allowing for a more continuous sleep. Besides the provision of regular pressure care, visual checks should be conducted at least every two hours to ensure residents are safe, comfortable, not experiencing any medical issues, pain, falls, or needing support with toileting.

Review documentation: The provider response included that at the time of [Mrs B's] admission, relevant worklogs were generated for her care requirements. However, in this instance it was the progress notes documentation rather than the usual eCase charting documentation that indicated how often the checks were completed. EV confirmed that over this period and due to COVID response generally all residents were visually monitored more frequently. The progress notes during this initial period in care include observations of pain on her right thigh and instances when she was repositioned.

On the night of 28 April 2022 [Mrs B] settled for the night around 20.00 hrs. Because the checks and repositioning actions were not charted it is unknown if these were carried out every two hours. The provider's response also concluded that it is not known if visual checks were carried out, as there is no evidence of this in any charting or documentation. The incident report states that at 1.30 hours, care staff who went to reposition [Mrs B] found the second-degree burn on her left knee. The Root Cause Analysis concluded that "*The wall heater came in direct contact with the lateral aspect of the [Mrs B's] left knee over the period of approximately 5–6 hours causing a second-degree burn.*"

Departure from accepted practice: In the situation that [Mrs B] did not receive visual checks or repositioning for an extended period of 5 to 6 hours during that night, this would be viewed negatively by my peers and be seen as a significant deviation from accepted practice due to poor care management. I note that there was no staff shortage that night.

Escalation of Burn Injury:

***Standard of care*:** A second degree burn damages the outer and second layer of the skin and causes blisters, pain and redness. The seriousness of such burn depends on the area

and size of the burn. **First aid** involves cooling by way of keeping the area for 10 to 20 minutes under cold running water. This can provide pain relief and prevent further tissue damage. Then cover with a sterile non-stick dressing. Depending on the severity of the burn and the overall health of the person who sustained it, the treatment should be escalated for a **medical review**. Typically, such incident would be picked up the next morning by a [senior staff member] in charge for follow up. When escalating a clinical concern for medical review the ISBAR tool is the preferred format for communication. The Oceania Clinical Escalation Pathway includes the use of this tool by nurses.

***Review of documentation and clinical advice**:*

First aid

[RN E] who was on duty when the incident happened writes in the incident report that [Mrs B] was resistant when the RN touched the side of the wound. She applied a wound dressing and advised care staff to keep [Mrs B] hydrated.

The progress notes include same. I did not find documentation of first aid treatment of the burn such as cooling the area under streaming cold water. Seeing the size of the burn it would have been recommended for the RN to have initiated moving [Mrs B] to the shower where the side of her leg could have been cooled under running water. This type of first aid can reduce the risk of complications such as infection and deeper tissue damage.

Departure from accepted practice: In the situation that the RN did not initiate the cooling of the burn this would be viewed by peers as a failure to adhere to basic well established first aid protocols and would be seen in the circumstances as a moderate deviation from accepted practice.

Medical review

On 29 April 2022, a Wound Chart was initiated recommending that the wound be redressed every 2 days. The Wound Chart shows that on 4 May 2022, the wound showed signs of infection and measured 15cm x 5cm with moderate pain. A wound swab was taken to check for infection, and pictures were taken of the wound to keep track of progress. I also note that family was regularly kept up to date on progress. I note that the documentation of the content of the family communication was very limited.

On 5 May 2022, the progress notes include "*client complained of moderate pain during dressing, noted moderate exudate … referred to NP for review of blood results and to chart burn ointment.*" [NP D's] response indicates that she was first asked to provide treatment for [Mrs B] on 6 May 2022. On that day, she was not onsite but was called by the RN and advised that [Mrs B's] wound looked infected. The results from the swab indicated an infection, and [NP D] charted antibiotics remotely.

Given [Mrs B's] co-morbidities and the fact that the wound resulted from an accident at the care home, it would have been prudent for the RN on duty at an earlier date to

have escalated the wound for medical review. In addition, when the RN escalated the concern of deterioration of the wound to the NP and considering the lockdown, it would have been better if the RN used the SBAR (Situation, Background, Assessment, Recommendation) tool to communicate a completer picture of the issue, including a photo of the wound.

It would be my recommendation for [NP D] to insist on receiving a more complete clinical picture, ideally in a written format of SBAR and accompanied by relevant pictures before agreeing to prescribe antibiotics. This approach would ensure that all necessary information is considered, leading to more informed and effective clinical decisions.

Departure from accepted practice: In conclusion I consider the escalation of the wound to the NP to have been a moderate to significant deviation from accepted practice because nurses who did the wound care did not seem to have identified the severity of the injury resulting in delayed escalation and substandard communication with the NP.

Staffing Constraints and COVID-19:

***Standard of care*:** Adequate staffing levels must be maintained to ensure the safety and well-being of residents. During times where there are staff shortages such as during the COVID-19 pandemic Clinical Managers can implement strategies such as the prioritisation of the most essential tasks and residents with the highest needs ensuring the most vulnerable receive the necessary care. Strategies can include utilising flexible staffing models, cross training of staff, leveraging technology, eliminating non-essential tasks, reducing administrative tasks etc.

Review of clinical documentation: The Root Cause Analysis identified several factors to consider at the time of the event and included that "*there were several staff off sick and nurses and HCAs were picking up extra shifts to cover the roster. … "*. Reviewing the staff roster the evening of 28 April 2022, it showed that several care staff were reported off sick. Other care staff had their hours extended till 23.15 hrs to ensure coverage until the start of the night duty. It appears that normal staffing levels were maintained during that night until the morning of 29 April 2022. The morning of the 29 April 2022 a significant number of staff called in sick, RN cover for the day was also impacted.

Departure from accepted practice: While I am understanding of the staffing challenges, not checking for a period of 5–6 hours on a resident dependent on staff for repositioning and the late and poor escalation of the wound for medical review represents still a departure from accepted practice. Peers would acknowledge the staffing challenges but still expect contingency plans to be in place that prioritise the most vulnerable and dependent on nursing input. In the situation that there was no such contingency plan for staff on the day supporting them on how they could prioritise their care tasks, this would be considered as a moderate deviation from accepted practice by my peers.

***Recommendations**:* Develop robust contingency plans for staffing shortages and ensure staff are adequately supported during such times with clear written and verbal instructions and abilities to prioritise the most vulnerable residents.

Management of Pain:

***Standard of Care*:**

Pain assessment and management are crucial, especially for residents with complex health needs like [Mrs B]. The standard of care involves regular, comprehensive pain assessments using validated tools appropriate for the resident's communication abilities, such as the Numeric Rating Scale (NRS), the Visual Analog Scale (VAS), or the Abbey Pain Scale for those with cognitive impairments.

Pain assessments should be conducted regularly, at least once per shift for residents who experience long term pain, and more frequently if the resident's condition changes or new pain is reported. All pain assessments should be documented, including intensity, location, and any non-verbal cues, especially for residents who have difficulty communicating. An individualized Pain Management Plan should be developed, incorporating both pharmacological (e.g., analgesics, anti-inflammatories) and non-pharmacological (e.g., physical therapy, relaxation techniques) interventions. Pain relief measures should be administered promptly, and their effectiveness evaluated.

Involving the resident and their family in the pain assessment process ensures they understand the pain management plan and the importance of promptly reporting pain.

Review of clinical documentation:

Similarly to the absence of a Care Plan and Repositioning Charts during April and May 2022, staff relied on progress notes until 20 May 2022, when a Pain Chart was commenced. This lack of a care plan means it might not have been clear to staff that [Mrs B] could have been experiencing altered sensation on her left side, impacting her ability to perceive and report pain accurately. A care plan could have recommended the most appropriate way to assess pain, such as using the numeric rating scale, considering [Mrs B's] situation and her ability to communicate in English.

Progress notes indicate that [Mrs B] was able to verbalize and report pain, such as neck pain on 21 April 2022, for which a PRN opioid was administered and followed by an evaluation. She also experienced pain in her right thigh at times, and the burn wound increasingly became a source of pain. Other times, the notes mention that no pain was noted or verbalized. It appears that staff regularly checked for and documented pain, even when none was present.

The Pain Chart implemented on 20 May 2022 has a gap of 10 days between 21 May 2022 and 31 May 2022. The chart includes a section to add a pain score, but this was not utilized by staff.

Departure from accepted practice: I consider the management of [Mrs B's] pain to have been a moderate deviation from accepted practice during April and May 2022, until 31 May 2022, when a pain chart was completed more consistently, though without scoring pain intensity. The absence of a care plan meant that staff may not have recognized potential altered pain perception and did not use a recommended consistent rating scale, no personalised non-medication pain management tools were consistently used.

Therefore, I consider pain management during that period to have been a moderate deviation from accepted practice.

Final Remarks — Clinical oversight:

The review identifies multiple departures from the standard of care provided to [Mrs B] during April and May 2022. The primary areas of concern include environmental safety, care planning, pressure care management, escalation of injuries, and management and guidance during times of staffing constraints.

The role of the Clinical Nurse Leader is crucial in ensuring the quality of care. The identified issues suggest there might have been a lapse in clinical oversight. It is important for the Clinical Nurse Leader or the RN in charge to ensure that all staff consistently adhere to Oceania's Policies and Procedures, especially in light of the issues identified above. A key aspect of effective clinical leadership is promptly identifying, reviewing, and following up on all incidents.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Nurse Advisor (Aged Care)
Health and Disability Commissioner'

Appendix B: Assessments completed for [Mrs B] on admission to Elmwood

Name of assessment	Assessments completed on admission	Notes
Communication and comprehension assessment	Not completed	
Continence assessment	Not completed	
Dietary assessment	Completed	
Medication assessment	Not completed	
Mobility and Transfers v2 assessment	Not completed	Oceania said that this assessment was completed on admission.
Oral and Dental assessment	Not completed	
Pain (Abbey) assessment	Not completed	Oceania said that this assessment was completed on admission.
Personal hygiene assessment	Not completed	
Pressure injury risk assessment	Not completed	Oceania said that this assessment was completed on admission.
Skin assessment	Not completed	Oceania said that this assessment was completed on admission.
Sleep assessment	Not completed	
Swallowing difficulties assessment	Not completed	
Toileting assessment	Not completed	

Appendix C: Pressure area care management and visual checks for [Mrs B]

Date and time	Comment	Frequency of repositioning noted?	Side of body noted
20 April 2022	'Turnings strictly monitored'	No	No
21 April 2022 at 12.58pm	'Turned'	No	No
21 April 2022 at 02.07pm	'positioning and pressure care done'	No	No
22 April 2022 at 2.00pm	'Turning and positioning to continue.'	No	No
22 April 2022 at 11.18pm	'Turning done at regular intervals.'	No	No
23 April 2022 at 4.07am	'Client … turned.'	No	No
23 April 2022 at 3.51pm	'To continue with pressure area cares … To continue with visual checks.'	No	No
24 April 2022 at 12.06pm	'Turned to relieve pain pressure on her [right] thigh.'	No	Not specifically, but noted she was turned off her right thigh; unsure if that is to her back or left side?
24 April 2022 at 10.31pm	'Continued with 2 hourly pressure area care … To continue with visual checks.'	No	No
25 April 2022 at 7.04am	'pressure ca[r]es applied during shift.'	No	No

26 April 2022 at 6.31am	'visual checks during shift.'	NA	NA
27 April 2022 at 6.52am	'Client … turned.'	No	No
27 April 2022 at 7.29pm	'Comfortable on checks … 2 [hourly] side turns done.'	Yes — 2 hourly	No
29 April 2022 at 11.55am	'regular turns'	No	No
29 April 2022 at 7.34pm	'turned.'	No	No
30 April 2022 at 3.54am	'checked and turned regularly.'	No	No
30 April 2022 at 1.43pm	'Turned and settled … [m]aintaining visual checks.'	No	No
30 April 2022 at 10.51pm	'To continue with regular pressure area cares … Visual checks maintained.'	No	No
1 May 2022 at 3.09pm	'turned onto [right] side.'	No	Yes — right side
1 May 2022 at 6.35pm	'Alert on checks.'	NA	NA
1 May 2022 at 8.11pm	'turned.'	No	No
2 May 2022 at 7.09pm	'Was up in her chair this evening.'	No	Yes — sitting up
3 May 2022 at 9.10pm	'2 [hourly] turns done.'	Yes — 2 hourly	No

4 May 2022 at 7.28pm	2 [hourly] side turns done.'	Yes — 2 hourly	No
5 May 2022 at 5.22am	'pressure cares applied during shift.'	No	No
5 May 2022 at 7.11pm	'2 [hourly] turns done.'	Yes — 2 hourly	No
Absence of two days of pressure area care recording			
8 May 2022 at 8.32pm	'2 [hourly] turns done.'	Yes — 2 hourly	No
9 May 2022 at 8.01pm	'2 [hourly] turns done.'	Yes — 2 hourly	No
10 May 2022 at 9.39pm	'hourly turns done on [right] side and back.'	Yes — hourly	Yes — right side and back
11 May 2022 at 9.35pm	'2 [hourly] turns done.'	Yes — 2 hourly	No
12 May 2022 at 2.33am	'visual checks during shift.'	NA	NA
12 May 2022 at 7.31pm	'2 [hourly] turns done.'	Yes — 2 hourly	No
13 May 2022 at 3.45am	're positioned.'	No	No
13 May 2022 at 1.16pm	'[Maintained] pressure cares and repositioning.'	No	No

13 May 2022 at 7.05pm	'Turns maintained.'	No	No
14 May 2022 at 2.37am	'visual checks during shift.'	NA	NA
14 May 2022 at 12.33pm	'[Maintained] pressure cares and repositioning.'	No	No
15 May 2022 at 8.21pm	'visual checks done.'	NA	NA
16 May 2022 at 2.44am	'visual checks during shift.'	NA	NA
16 May 2022 at 9.11pm	'2 [hourly] turns done on [right] side and back.'	Yes — 2 hourly	Yes — right side and on to back
17 May 2022 at 10.31pm	'Nursed on [right] side and back.'	No	Yes — right side and back
18 May 2022 at 2.58am	'pressure cares applied during shift.'	No	No
18 May 2022 at 8.22pm	'2 [hourly] turns done on [right] side and back.'	No	Yes — right side and back
19 May 2022 at 5.43am	'pressure cares applied during shift.'	No	No
19 May 2022 at 9.29pm	'2 [hourly] turns done.'	Yes — 2 hourly	No
20 May 2022 at 5.39am	'turned.'	No	No
20 May 2022 at 1.04pm	'pressure cares and repositioning.'	No	No
20 May 2022 at 10.25pm	'Turning done every 2 hours.'	Yes — 2 hourly	No

21 May 2022 at 2.46am	'pressure cares applied during shift.'	No	No
On 21 May 2022 around 7.30pm, [Mrs B] was transferred to hospital for debridement and a skin graft. She returned to Elmwood on 31 May 2022.			

Appendix D: [Mrs B's] pain management

Date and time	Progress notes entry	Pain scale used	PRN pain relief given	Effect of pain relief noted
On 21 April 2022 at 8.45am	RN documented: 'Wound location: Right hip.'	Yes — 6/10 '[Mrs B] was noted to be tapping her neck shoulders hips when asked if in pain.'	Yes — oxycodone 2mg	Yes — 'no pain noted, client is asleep.'
24 April 2022 at 6.53am	[RN H] documented that [Mrs B] 'woke up and has been tapping both her legs … seems [to be in] discomfort, PRN opioid elixir was given at 6.24am with good effect. Please see medimap for details.'	Yes — 'She's tapping both legs. Unable to verbalise pain score.'	Yes — 2mg oxycodone liquid	Yes — 'more settled, asleep.'
On 25 April 2022 at 5.25am	RN … documented that [Mrs B] was '[g]iven PRN [a]nalgesia for left [thigh] pain 5/10 [on pain] scale (see medimap for details) with good effect. Nil further complaint of pain at the time of evaluation.'	Yes — 5/10	Yes — paracetamol 500mg oral liquid	'Nil signs of discomfort indicative of pain at the time of evaluation. Resident sleeping. Pain 0.'
On 28 April, [Mrs B] sustained a second-degree burn injury to her left thigh				
On 29 April 2022	[RN E] documented that when checking her burn injury [Mrs B] had been settled, but	No	No	No

	'she was resistant when the author touched the side of the wound.'			
On 1 May 2022 at 6.04am	[RN H] documented that [Mrs B] complained of pain in both legs and feet and 'PRN analgesia was given at 0532 with good effect. Please see medimap for details …'	Yes — 5/10	Yes — 500mg oral liquid paracetamol	Yes — 'more settle[d].'
On 3 May 2022 at 12.18pm	[RN I] documented that [Mrs B] 'verbalized moderate pain during dressing'.	No	No	No
On 4 May 2022 at 11.30am	[RN I] documented that during the wound dressing [Mrs B] 'complained of moderate pain during dressing'.	No	No	No
On 5 May 2022 at 3.01pm	[RN I] documented that [Mrs B] 'complained of moderate pain during dressing'.	No	No	No
On 6 May 2022 at 12.15pm	RN … documented that [Mrs B] '[expressed] pain on touch during dressing'.	No	No	No
On 8 May 2022 at 11.00am	RN … documented that [Mrs B] '[expressed] pain on touch during dressing'.	No	No	No

On 9 May 2022 at 2.00pm	[RN F] documented that [Mrs B] 'reported pain on her legs, regular analgesia and other due medications given as charted'.	No	No	No
On 10 May 2022 at 10.52am	[RN I] documented that [Mrs B] 'complained of moderate pain during dressing'.	No	No	No
On 11 May 2022 at 3.46am	RN … documented that Mrs B 'complained of abdominal and leg pain and was given prn opioid with good effect (see medimap)'.	Yes — 6/10	Yes — 2mg of oxycodone liquid	Yes — 'with good effect'.
On 12 May 2022 at 2.55pm	[RN I] documented that [Mrs B] '[had] moderate pain during dressing'.	No	No	No
On 13 May 2022 at 1.16pm	RN … documented that [Mrs B] 'complain[ed] of pain' during the wound dressing.	No	No	No
On 14 May 2022 at 12.33pm	RN … documented that [Mrs B] complained of pain during the wound dressing.	No	No	No
On 16 May 2022 at 10.53am	[RN F] documented that [Mrs B] 'reported pain [in] her legs, regular analgesia and other due medications given as charted'.	No	No	No

On 20 May 2022 at 1.04pm	RN … documented that [Mrs B] expressed pain during the dressing change.	No	No	No
On 20 May 2022 at 10.25pm	RN … documented: 'Pain was relieved with regular medications.'	No	No	No
On 21 May 2022 at 5.40am	[RN H] documented that [Mrs B] 'complained of pain on left leg, she was tapping on it multiple times. PRN opioid elixir was given at 0003 with good effect. She was settled after an hour.'	No	Yes — opioid elixir	Yes — 'she was settled after an hour.'
On 21 May 2022, [Mrs B] was admitted to hospital for debridement and skin graft and returned to Elmwood on 31 May 2022.				