Heritage Lifecare Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01213)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman by Heritage Lifecare Limited in 2018, particularly the management of her pressure wounds and her pain.

2. There is no documented evidence that the woman was turned regularly every two hours following discovery of her pressure wounds, or that her wounds were dressed daily as instructed by the general practitioner (GP). Rest home staff did not seek a review or assistance from the wound care specialist or the GP until around two months after the wounds were first discovered. The observations and progress of the wounds were not documented appropriately, and despite the rest home's wound policy that photographs of pressure wounds should be taken weekly, this was not done.

3. The first pain assessment conducted for the woman was six weeks after the discovery of the pressure wounds, and the woman's pain was not assessed at every wound dressing in accordance with the rest home's wound policy. The rest home also did not administer PRN morphine regularly when the woman's dressing was changed, and PRN morphine was not used consistently when the woman felt pain.

4. The family was first informed about her pressure wounds around a week after the wounds were first discovered. However, the family was not provided with any further update about the wounds until three months later.

Findings

5. The Deputy Commissioner found that the rest home did not provide appropriate care to the woman for her pressure wounds, and that the pain management associated with her wounds was inadequate. Accordingly, the Deputy Commissioner found the rest home in breach of Right 4(1) of the Code.

6. The Deputy Commissioner was also critical that the rest home did not keep the family updated and fully informed about the woman's deteriorating wounds, and was concerned by the lack of clear guidance as to who had the overall responsibility of the Clinical Services Manager role at the rest home.

Recommendations

7. The Deputy Commissioner recommended that the rest home conduct an audit of staff compliance with its policies; conduct an audit of wound documentation for 10 residents; report back to HDC regarding the implementation and effectiveness of the changes made; and apologise to the woman's family.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided by Heritage Lifecare Limited to her mother, Mrs A. The following issue was identified for investigation:

- *Whether Heritage Lifecare Limited provided Mrs A with an appropriate standard of care between Month2[1] and 12 Month6 2018.*

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

10. The parties directly involved in the investigation were:

Mrs A	Consumer
Mrs B	Complainant
Heritage Lifecare Group	Provider

11. Also mentioned in this report:

RN C	Senior registered nurse
RN D	Wound care nurse
RN E	Registered nurse
Dr F	GP
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse
RN J	Registered nurse
RN K	Registered nurse
RN L	Facility Manager
RN M	Clinical Services Manager
RN N	Quality Coordinator
RN O	Registered nurse

12. Independent expert advice was obtained from Registered Nurse (RN) Pachel Parmee (Appendix A).

[1] Relevant months are referred to as Months 1–6 to protect privacy.

Information gathered during investigation

Background

13. In 2014, Mrs A, aged in her eighties at the time of events, was admitted to a rest home owned and operated by Heritage Lifecare Limited. Mrs A was frail and had dementia. Both Mrs B and Mrs A's other daughter held an enduring power of attorney (EPA)[2] for Mrs A. On 17 Month1, Mrs A was diagnosed with cachexia.[3]

14. This opinion concerns the care Mrs A received at the rest home from Month2 to Month6, in particular the management of her pressure wounds[4] and pain.

Sacral pressure injury management

Discovery of pressure wound

15. The progress notes on 25 Month1 record that Mrs A had two small lesions on her sacrum.[5] A Turning Chart was commenced and a two-hourly turning routine was implemented.

16. On 28 Month1, it was noted that Mrs A's sacral area was improving, and on 30 Month1, Mrs A's sacrum was noted to have "recovered". On 5 Month2, nursing staff recorded: "[S]acrum looking good." From 5–14 Month2, no concerns about Mrs A's sacrum were noted.

17. On 14 Month2, the progress notes document:

> "[Mrs A] has been visited by daughter. Carer reported while giving shower that there is broken area on the bottom. On assessment, found 2 broken areas on the sacrum, cleaned and dressing applied. Wound care plan is updated and follow the turning chart. Monitor for further changes and report it."

18. The rest home told HDC that the pressure area on Mrs A's sacrum was first noticed on 16 Month2. A Pressure Area Risk Assessment form was first completed on this date, and Mrs A was scored as 10.[6] A Soft Tissue Care Plan form described the pressure injuries as "1 on each buttock", and noted that "2 hourly turning should be continued".

19. The Soft Tissue Care Plan form required skin tears to be categorised according to the STAR Skin Tear Classification,[7] including the stage of the pressure injury.[8] However, this section

[2] A legal document that sets out who can take care of a person's personal or financial matters if that person is unable to.
[3] Extreme weight loss and muscle wasting caused by severe chronic illness.
[4] Initially, Mrs A had two pressure wounds on her sacrum. As the wounds deteriorated, they merged into a single wound.
[5] The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis.
[6] A score of 14 or less indicates that a resident is at risk of developing a pressure area injury. The lower the score, the higher the risk.
[7] Skin tears can be classified according to the Skin Tear Audit Research (STAR) classification system: category 1a, b, 2a, 2b, or 3. Category 1a (a skin tear where the edges can be realigned to the normal anatomical

was not completed. The form also provided a "description for evaluation" of the pressure injury, being pain, bleeding/oozing, slough, necrosis,[9] colour, temperature, surrounding skin, and size. However, only smell and colour were noted on the form.

20. On 20 Month2, Mrs A's nutrition was reviewed. The Nutrition Profile form noted that she should be given a high protein diet. The progress notes record that Mrs A continued to be repositioned, and that cream was applied to her sacrum.

21. On 23 Month2, the progress notes document that Mrs A's family was informed about the pressure wound.

22. According to the Soft Tissue Care Plan, Mrs A's pressure wound was cleaned daily throughout Month2.

23. On 5 Month3, another Soft Tissue Care Plan form was completed (as the pages in the previous document had run out). The pressure wound was described as "0.5cm x 0.25cm and 1cm x 0.5cm". The STAR Skin Tear Classification and stage of pressure injury were not completed on the form.

24. Neither the Soft Tissue Care Plan nor the progress notes document that Mrs A's wound was cleaned or the dressing changed on 6, 7, 8, 10, and 12 Month3. On 16 Month3, the Soft Tissue Care Plan noted that the dressing was checked and still intact.

25. On 22 Month3, the progress notes record that Mrs A's pressure wound had deteriorated, and that the wound plan was reviewed and an air mattress placed on her bed to avoid progression of the wound. It was also documented that a photograph of the wound was taken. However, this was not provided to HDC.

26. From 16–31 Month3, the progress notes show that Mrs A's dressing was changed daily, except on 20 and 25 Month3.

Wound care nurse assistance

27. On 6 Month4, Senior RN C documented in the progress notes that Mrs A's dressing was wet with blood and that the pressure wound had deteriorated. RN C emailed a wound care specialist, RN D, to ask for advice about Mrs A's sacral wound, and included a photograph of the wound taken that day. RN C's email stated:

> "I would like to seek your expertise related to managing this stage 3 sacral pressure injury (attached photo) … Sacral Stage 3[10] pressure injury, no pain, no exudate[11] but

position) is the least serious, and category 3 (a skin tear where the skin flap is completely absent) is the most severe.

[8] The Soft Tissue Care Plan form provided six stages of pressure injury.

[9] Death of body tissue.

[10] A stage three pressure injury is defined as full thickness skin loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present.

[11] Fluid that oozes out of blood vessels into nearby tissues.

was bleeding this morning, very minimal slough, no odour and not painful to touch, redness in the surrounding skin …"

28. A copy of RN C's email was provided to HDC.

29. RN C also sent a Notification of a Pressure Injury form to HealthCERT.[12] The form recorded that the pressure injury was categorised as stage three.

30. RN E recorded in the clinical notes: "[N]eeds appropriate wound care plan, need to change dressing daily, informed pressure injury to [RN D] wound nurse specialist[13] today."

31. A new Soft Tissue Care Plan form completed by another nurse on 6 Month4 described the pressure wound as "stage [two]". The evaluation section of the form noted: "S[lough] — 0, C[olour] — red, Su[rrounding skin] — red and broken, N[ecrosis] — 0, P[ain] — 0 ..." The Soft Tissue Care Plan documented that the wound was to be cleaned with saline[14] and dressed with a SoloSite[15] dressing. However, from 9 Month4 onwards, not all the required information was included in the description and evaluation sections of the Soft Tissue Care Plan. On some days, only the smell and slough were noted, and on other days the notes documented "no change".

32. On 9 Month4, RN D responded to RN C's email and advised: "[T]his wound maybe better with Iodosorb[16] into the cavity." RN D asked RN C to update her on any further progress. The progress notes on this date record: "[P]ressure area deteriorated, photos [of the wound] updated, referral sen[t] to [Dr F], GP, regarding infection." There is no further documentation about the communication with Dr F on 9 Month4. The rest home told HDC that Dr F was telephoned on 9 Month4 and he prescribed antibiotics, which commenced on 10 Month4.

33. The progress notes on 25 Month4 recorded: "[N]o improvement in wound healing."

Wound dressing changes in Month4

34. In Month4, the progress notes and the Soft Tissue Care Plan form document that the dressing on Mrs A's sacrum was changed daily, except on 2, 5, 8, 12, 15, 17, 19, and 23 Month4. On these dates, it was documented in the progress notes that the existing dressing was intact.

[12] HealthCERT is responsible for ensuring that hospitals, rest homes, residential disability care facilities, and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001.
[13] RN D is a specialist wound nurse at the DHB. The DHB's District Nursing Service provides specialist nursing care in the community.
[14] A mixture of salt and water.
[15] A gel dressing used to create a moist environment for the treatment of wounds.
[16] A medicated dressing used to assist healing of wounds.

Second communication with wound care nurse

35. On 9 Month5, the progress notes record that a photograph of the pressure wound was taken and emailed to RN D. However, HDC was not provided with the photograph or the email sent to RN D from the rest home on this date.

36. On 14 Month5, RN C emailed RN D as the pressure wound was deteriorating. RN C sent another photograph to RN D and asked whether any change should be made to the current dressing. The photograph showed that one wound was 3.5–4cm wide, and the other wound was 3–3.5cm wide. RN C's email stated: "[I]t was pressure wound on sacral area, still with slough, decreased redness in the surrounding skin but I reckon was getting bigger."

37. RN D responded in the afternoon on 14 Month5 and advised that Prontosan[17] soaks and Prontosan gel should be used.

Third communication with wound care nurse

38. On 31 Month5, RN C sent another email to RN D advising that they had substituted Prontosan gel with octenilin gel, and attaching a photograph of the wound taken on this date. No measurements were provided with the photograph, but the image showed that the wound size had increased and the wound had deteriorated. RN C stated in her email: "I just don't know what else we can do."

Wound dressing changes in Month5 and Month6

39. In Month5, documentation in the progress notes and Soft Tissue Care Plan indicates that Mrs A's dressing was changed daily. An evaluation of Mrs A's wounds was noted every day except for 1 and 11 Month5.

40. On 1 Month6, there is no documentation in the progress notes, Abbey Pain Scale, or Soft Tissue Care Plan to indicate whether Mrs A's wound dressing was changed, or her level of pain.

41. On 2 Month6, another Soft Tissue Care Plan was completed, with the injury noted as: "[P]ressure area stage 3. Description: Chronic." The STAR Skin Tear Classification was categorised as 3. This was the first STAR Skin Tear Classification on the Soft Tissue Care Plan.

42. From 2–12 Month6, the progress notes and the Soft Tissue Care Plan document that Mrs A's dressing was changed daily.

Turns

Turns in Month2, Month3, and Month4

43. As noted above, Mrs A was on a two-hourly turning regimen. Her Turning Chart was provided to HDC. The rest home's Turning Chart form stated: "Please fill out correctly and honestly. If you think it will need changing soon (over half full but room to go), say so! ... please initial when the turning is completed." The Turning Chart also stated that staff

[17] Solution used to clean and moisturise wounds.

should note when the patient attended the toilet or when the night pad was in place. In response to the provisional opinion, Mrs B told HDC that this was unlikely to be noted as her mother was incontinent.

44. On a number of days in Month2, Month3, and Month4, rest home staff did not document whether Mrs A was turned every two hours. In addition, staff did not initial the Turning Chart following the documentation of turns, and did not note when Mrs A attended the toilet or when she wore a night pad. In response to the provisional opinion, Mrs B told HDC that the majority of the time she visited, she found her mother sitting in a recliner chair, and, because of this, Mrs B believes that her mother was not turned.

45. The table below provides a summary of the days and times in Month2 when turns were not documented in the Turning Chart.

Month: Month2			
Date	**Time (where no record of turns)**	**Date**	**Time (where no record of turns)**
2	2pm to 11pm	12	6am to 11pm
3	6am to 3pm	13	6am to 10pm
4	6am to 7pm	14	No records
5	6am to 1pm, 3pm to 8pm	15	No records
6	6am to 10am	16	12am to 2pm
7	6am onwards	21	3am to 9am
9	8am to 3pm	22	6am to 12pm
10	No records from 6am	24	6am to 4pm
11	6am to 7pm	25	9am to 2pm

46. The table below provides a summary of the days and times in Month3 when no turns were documented in the Turning Chart:

Month: Month3			
Date	**Time (where no record of turns)**	**Date**	**Time (where no record of turns)**
11	6am to 3pm	23	6am to 7pm

12	6am to 6pm	24	6am to 1pm, 2pm to 9pm
13	2pm to 6pm	25	6am to 4pm
16	6am to 7pm	26	6am to 4pm
18	6am to pm	27	6 am onwards
19	6am to 8pm	28	3pm to 7pm
20	6am to 11pm	29	6am to 4pm
21	6am onwards	30	6am to 7pm
22	6am to 3pm	31	6am to 8pm

47. The table below provides a summary of the days and times in Month4 when no turns were documented in the Turning Chart:

Month: Month4			
Date	**Time (where no record of turns)**	**Date**	**Time (no record of turns)**
1	10am onwards	10	9am to 7pm
2	6am onwards	11	12pm to 8pm
3	6am to 11pm	12	10am to 11pm
4	12pm to 8pm	13	2pm to 10pm
5	8am onwards	15	6am to 7pm
6	8am to 6pm	16	11am to 7pm
7	2pm to 7pm	19	2pm to 11pm
8	10am 11pm	24	1pm to 6pm

Turns in Month5 and Month6

48. In Month5, Mrs A was turned every two hours, and this was documented in the Turning Chart except on 12 Month5, when there was no documentation about turning from 6am to 7pm.

49. The Turning Chart also showed that Mrs A was turned two hourly every day in Month6 before she passed away.

Information from staff about turns

50. Regarding whether Mrs A was turned two hourly, HDC sought statements from several registered nurses who cared for her. The relevant statements are as follows:

a) RN H told HDC: "I am not able to remember any specific times that [Mrs A] was not turned when I was on duty. I recognise the importance of maintaining position changes in pressure area management."

b) RN G told HDC: "On [25 Month3] I wrote in the progress notes that [Mrs A] was turned regularly, unfortunately this is not shown on the turning chart. I am sure she was turned regularly when I was on shift, but there is not always evidence of this written down, some of the turning chart was blank."

c) RN I said: "I have noticed in the progress notes that [Mrs A] was up in the lounge several times during the day and therefore her position was changed when she was moved from her room. This should have been recorded in the Turning Chart and this does not seem to have been done."

d) RN E told HDC: "As per my knowledge, [Mrs A] was repositioned daily at regular intervals … It was handover to the care staff during every shift to reposition all the residents who are at risk of getting pressure areas and was supervised as well."

e) RN J said: "I instructed all the care staff to turn [Mrs A] every 2 hourly and instructed them to document it as well. I am unable to recall why she was not turned on the specific mentioned dates."

f) RN K told HDC: "Whenever I work in the Hospital wing [I] have always made sure [Mrs A] was turned and, [on] many occasions, I have helped carers to turn [Mrs A]."

Pain management and GP review

First pain assessment — Month3

51. It was noted in the Soft Tissue Care Plan on 24, 28, and 29 Month3 that Mrs A felt no pain. These notes were the first documented pain assessments since Mrs A's wound was discovered in Month2. The Pain Chart was not completed at this time.

Pain management and GP reviews

52. According to the Soft Tissue Care Plan, Mrs A first felt pain on 9 Month4 when the wounds were cleaned or touched. Pain from the wounds continued to be noted on 10, 11, 13, and 14 Month4 in the Soft Tissue Care Plan. Nursing staff did not seek any further assistance or make any referral to the GP about this pain.

53. On 18 Month4, another Soft Tissue Care Plan form was completed, and described the wound as "stage 3". The skin tear classification was not completed. On 22 Month4, the Soft Tissue Care Plan noted that Mrs A was experiencing pain.

54. On 26 Month4, Dr F reviewed Mrs A as per his normal scheduled three-monthly GP review. The rest home told HDC that at this consultation, Dr F reviewed Mrs A's pressure wound. This was also the first time that a GP had reviewed Mrs A for pain management. Dr F recorded in his clinical notes: "[A]ppeared comfortable. Still large defect at sacrum. Pressure relief plan in place. Healing will be impaired due to lack of mobility [and] cachexia. Requires analgesia."

55. According to the medication chart, Dr F prescribed 5mg oral morphine. Dr F noted: "[R]eason started: pain with dressing. Dose approx. 9am."

56. On this date, the Pressure Area Risk Assessment form was completed again, and Mrs A was given a score of 9. The progress notes record that Dr F reviewed Mrs A and advised: "[Mrs A] needs to have wound care each day after shower [or] wash."

57. The Medications Administration Chart shows that Mrs A was first given 5mg of morphine at breakfast time on 27 Month4, and continued to be administered morphine once a day at breakfast time from 27 Month4 to 24 Month5.

58. On 3 Month5, the Medications Administration Chart notes that Dr F prescribed oral liquid morphine 5mg PRN.[18] The chart records that PRN morphine 5mg was first given to Mrs A on 14 Month5, and that previously it had been "given prior [to] dressing".

59. In response to the provisional opinion, Mrs B said that on 19 Month5, she had to request an increase in PRN morphine for Mrs A, and her mother was sitting in a chair, not in bed.

60. On 22 Month5, the progress notes record that Mrs A's pressure wound had deteriorated. Mrs A's nutrition was reviewed, and the Nutrition Profile form documents that further supplements were to be given. A Pressure Area Risk Assessment form was completed (the third since Month2), and Mrs A was given a score of 9.

61. A Pain Chart was also commenced on 22 Month5, and it was noted that there were "no signs of pain". On 23 Month5, it was noted in the Pain Chart that Mrs A had "facial grimace, indicating pain". According to the Medication Administration Chart, Mrs A was given PRN oral morphine twice on this date. Mrs B said that she saw the staff changing her mother's dressing, and the staff were making her mother stand and hold onto her walker with two carers assisting, while the registered nurse changed the dressing. Mrs B said that her mother should have been lying on her bed when the dressing was done.

62. Mrs A was reviewed by Dr F at 9.30am on 24 Month5. Dr F noted:

[18] As necessary.

> "Pain appears to be more of an issue. There are few options for her other than ensuring optimal dressings/cover. Surgery is not indicated. Essentially, at end of life. Needs optimal analgesia for now, regular short acting morphine [and] attention to PRN needs. If frequent PRN doses will need further increase …"

63. Following his assessment, Dr F increased Mrs A's regular morphine to four times a day, and prescribed PRN medications that included 2.5 to 5mg of injectable morphine hourly. This was administered to Mrs A once, at 10.33am on 24 Month5.

64. The progress notes on 24 Month5 record that Dr F advised staff to increase Mrs A's analgesia and to use the Abbey Pain Scale. It was also noted that Dr F had spoken to Mrs A's family about her pain relief and her current condition. The Abbey Pain Assessment Scale[19] was used to assess Mrs A's pain from this date.

65. According to the Medications Administration Records, from 24 Month5 onwards, Mrs A was given morphine four times daily, at breakfast, lunch, 4pm, and bed times.

66. At 2pm on 25 Month5, the progress notes document that Mrs A's daughters visited and asked to see the nursing progress notes and wound plan. The notes record: "[R]eferred to manager." The Abbey Pain Assessment Scale was used to calculate Mrs A's scores of 4 at 5.30pm, 5 at 8pm, and 4 at 10pm.[20] Mrs B told HDC that the rest home told her that they needed permission from Heritage Lifecare management before she could read the notes.

67. From 26–30 Month5, the Abbey Pain Assessment Scale was completed several times daily, and Mrs A was given a pain score of 3–4 each day. Mrs B said that she visited her mother on 26 Month5, and her mother did not smile anymore and the family noticed obvious signs of pain.

68. On 28 Month5, an interRAI[21] Outcome Scale was completed for Mrs A, with a pain score of 3 out of 4. She had a low BMI of 18,[22] and a score of 4 out of 8 for pressure ulcer risk.

69. On 14, 28, and 29 Month5, Mrs A was given PRN oral morphine before her dressing was changed. In Month5, these were the only days on which Mrs A was administered PRN morphine before her dressing was changed.

70. At 10.10am on 31 Month5, the progress notes document that Dr F reviewed Mrs A and her level of pain relief, and advised to continue to use the Abbey Pain assessment and to let him know if there was an increase in the regular need of PRN medications. At 11am, the progress notes record that Mrs A was experiencing pain and was uncomfortable. The

[19] The Abbey Pain Scale is best used as part of an overall pain management plan, and for assessment of pain in patients who cannot verbalise.
[20] According to the Abbey Pain Scale, a score of 3–7 indicates mild pain.
[21] A suite of clinical assessment instruments. In New Zealand, interRAI is the primary assessment instrument in aged residential care and home and community services for older people living in the community.
[22] If the BMI is less than 18.5, the person is in the underweight range.

Abbey Pain Scale was completed, and Mrs A was given a pain score of 6. She was administered PRN oral morphine, and by 5pm her pain score had reduced to 4.

71. From 2 Month6 onwards, multiple daily pain assessments (around 6–8 per day) were completed using the Abbey Pain Scale. All of Mrs A's pain scores were categorised as mild pain (a score of 3–7).

72. From 2–12 Month6, the progress notes document that regular morphine was administered and the Pain Chart was updated.

73. The rest home told HDC: "Based on the assessment they made of [Mrs A] using Abbey Pain Scale, our Registered Nurses believed they administered analgesia appropriately."

Communication with family

74. On 20 Month5, the progress notes record that Mrs A was visited by her daughter, Mrs B, who was shown Mrs A's pressure wound. This was the first time Mrs A's family had been updated about the pressure wound since 23 Month2.

75. Mrs B told HDC:

> "[T]he family was never informed of the severity of this so called pressure area and it was by accident that I happened to visit my mother as they were changing her dressing."

76. The rest home stated:

> "We can only apologise for not informing [Mrs A's] family that the wound deteriorated. We acknowledge that this appears to be a miscommunication between our Registered Nurses."

77. On 5 Month6, the progress notes document that Mrs A's daughters asked to review the wound chart and progress notes, and that a registered nurse would sit with them the following morning while they read the documents. In response to the provisional opinion, Mrs B told HDC that she was told that she could read the notes only with supervision, and she was questioned why she would want to read the notes.

78. On 6 Month6, the Facility Manager, RN L, and the Interim Clinical Service Manager, RN C, met with Mrs A's daughters and gave them the opportunity to review Mrs A's clinical notes. The meeting minutes documented by RN L stated:

> "I have apologized to them both and promised to address all their issues … Their major issue (for which I apologized several times) was we did not keep them up to date with their Mother's wound. They were not aware that it had deteriorated to the extent that it has and were 'horrified' when they saw it (happened to walk in while dressing was being changed). I acknowledged that this was not appropriate and that we should have kept them up to date (apologized again)."

79. In response to the provisional opinion, Mrs B said that RN L did not apologise to her at the meeting as she noted. Mrs B said that she asked for a meeting because she was very concerned about how the rest home handled the care of the pressure wounds, especially the pain management and comfort provided to her mother.

Subsequent events — end-of-life care

80. On 7 Month6, RN D responded to RN C's email dated 31 Month5 and advised that she needed to assess the wound in person, and that keeping pressure off the wound was a priority. An appointment was arranged for 13 Month6.

81. According to the Medications Administration Chart, Mrs A was given PRN oral morphine on 7, 8, and 9 Month6 when her dressing was changed.

82. The rest home told HDC: "Our diversional therapist believes [Mrs A] meaningfully participated in social interaction mainly by watching and smiling, up until 8 [Month6]."

83. From 8–12 Month6, comprehensive notes of Mrs A's condition and her pain level were recorded in the progress notes daily. It was noted that her dressing was changed daily and that PRN morphine was given. The Medications Administration Chart records that Mrs A was given PRN morphine on five occasions on 11 Month6.

84. In response to the provisional opinion, Mrs B said that when she visited her mother on 11 Month6, she was the one who first requested the morphine pump to be used, as she did not want her mother to continue to suffer anymore. Mrs B said that it was always the family who had to ask the nursing staff for PRN morphine to be given to Mrs A, especially in the final few days before she passed away.

85. At 9.50am on 12 Month6, RN C noted:

> "Informed [Dr F], GP, that [Mrs A] is recurring every 2 hours of PRN pain medication and asked him if it's okay to start a syringe driver medication.[23] Received a phone call from [Dr F] around 9.55am and said will update medimap.[24]"

86. On the same day, Dr F prescribed 20mg of morphine daily to be administered via syringe driver. Mrs A's Nutritional Assessment[25] was also completed, and she was given a score of 22 (low risk).

87. Mrs A was administered 20mg morphine at 11.43am, and 5mg PRN morphine at 1.02pm after her wound dressing was changed. The syringe driver was started at 2.15pm.

88. An entry in the progress notes at 7.45pm noted that Mrs A passed away at 4.04pm, and that her family was present at the time of death. The rest home informed Dr F of Mrs A's

[23] A syringe driver administers medicines subcutaneously over a selected time period.
[24] Medi-Map is a platform used to assist medication management by healthcare providers in care facilities.
[25] An in-depth evaluation of an individual's food and nutrient intake, lifestyle, and medical history.

death. In response to the provisional opinion, Mrs B told HDC that the family stayed with Mrs A until she passed away, and they made sure that she had PRN morphine two hourly when the staff forgot.

Root Cause Analysis

89. Following notification of the complaint to HDC, the rest home conducted a Root Cause Analysis (RCA). A copy of the RCA report was provided to HDC. In summary, the report stated:

a) No documented evidence is available that indicates that the pressure injury was staged in the period 16 Month2 to 6 Month4.

b) On 23 Month2, Mrs A's family was informed about the pressure wound. The RCA noted: "Unfortunately we could not find any further mention of EPOA being updated on the status of the pressure injury."

c) "[Mrs A's] care plan did not include all strategies to address known risk factors or factors that could compromise wound healing; assessment of pain was not consistently well documented; turning charts were not consistently completed when [Mrs A] was turned and or mobilised."

d) "Care staff did not fully comply with all Heritage Lifecare policies, procedures and processes … There was also a lack of consistency in the use of the correct assessment and monitoring tools, and not all documents were completed correctly as per [Heritage Lifecare] policy."

e) There were delays in seeking medical review, and there was limited access to specialist nursing support.

Management and staff at the rest home

90. The rest home told HDC that from Month2 to Month6, around 13 registered nurses and 30 healthcare assistants provided care to Mrs A, or were involved in her care, and that three registered nurses provided senior oversight:

1. RN M, who was the Clinical Services Manager (CSM);
2. RN C, who was the senior registered nurse at the rest home from 12 Month3, and became the interim Clinical Services Manager on 30 Month4; and
3. RN N, the Quality Coordinator.

91. The Facility Manager of the rest home at the time was RN L.

92. RN M told HDC that she was seconded to another rest home from 1 Month2, and from 15 Month2 she was seconded full time at the other rest home. She said that she commenced work permanently at the other rest home in Month5, and was not directly involved with Mrs A's care, and was unaware of Mrs A's wound.

93. RN N told HDC that she had minimal involvement in Mrs A's care, as she did not often work on the floor in the role of a registered nurse. She also said that she was managing GP rounds, as the Clinical Services Manager had been seconded to another site.

94. RN L told HDC that she did not provide care to Mrs A, was not involved in the management of her wound, and was not advised by the Clinical Services Manager that Mrs A's condition was deteriorating.

95. RN L stated: "[RN M] was seconded to [another rest home] but was still available by phone and email. [RN M] would call in to [the rest home] every couple of days." RN L also said that the rest home was "only able to appoint an interim CSM while [RN M] was seconded to [another rest home] as [RN M] was still technically the CSM at the rest home", and that "[RN C] took over the CSM role in everything but name".

96. RN C told HDC that she started at the rest home on 19 Month3, and worked in the dementia unit as the Unit Coordinator, and was not asked to pick up the Clinical Services Manager role until late Month4. She stated: "[M]y understanding was that we should contact [RN M] for any CSM queries."

Further information from Mrs B

97. Mrs B told HDC:

> "[My mother] was given Morphine before they did the dressing but on several occasions I had to ask the RN to give her more afterward as I could clearly see she was in pain. The staff should have observed this.
>
> …
>
> I don't believe the staff looked after my mother as well as they could have. I know they didn't put her onto her bed when they should have and they didn't regularly turn her. I believe I owe it to my mother to speak on her behalf and for the other residents in this facility."

Further information from the rest home

98. The rest home told HDC:

> "We agree that a number of errors were made in the care of [Mrs A], and that this has served to improve service delivery … On behalf of Heritage Lifecare, please accept my sincere apology that [Mrs A] and her family members had such an experience that fell short of their expectations …"

99. The rest home also stated:

> "Heritage Lifecare Limited purchased [the rest home] … less than 12 months prior to this incident. At the time [we] were working with staff to embed our quality systems. One of the learnings for us following purchase of new care homes has been to

increase the 'whole of systems' auditing to ensure that Heritage Lifecare quality systems are being embedded."

Changes made since incident

100. The rest home told HDC that as a result of this incident, it addressed issues and made several improvements, including the following:

a) Instigation of Primary Nursing. The rest home stated: "[W]hile every Registered Nurse is responsible for the care of our Residents, one Registered Nurse is ultimately responsible for each Resident. It is up to this Nurse to ensure that Family are advised of all changes in condition."

b) The Clinical Manager must review all wounds at least twice weekly, or as required, and often will participate actively in treatment. The Clinical Manager also now seeks regular input and advice from the local DHB specialist wound nurse as soon as required.

c) The Clinical Manager will telephone a resident's family immediately following a review by a doctor.

d) Recently all registered nurses renewed their training on syringe drivers, which included education on pain management.

e) All registered nurses received pressure area management education that included specialist equipment and general nursing/skin care.

f) The education programme at the rest home addressed pain management, which in 2018 and 2019 was conducted by Dr F. Further education sessions about nursing assessment were delivered on site by a local Primary Health Organisation Clinical Nurse Specialist. In addition, the rest home has been involved in a pilot project focusing on geriatric assessment and early intervention.

g) A number of policies and processes were reviewed.

h) The internal auditing schedule was reviewed. This included a rewrite of most of the Heritage Lifecare Limited internal audit tools, with a focus on improving compliance with all aspects of the related policies and procedures. The rest home said that following receipt of HDC's expert advisor's report, an additional wound care audit tool was developed and added to the internal auditing schedule, and wound management is now audited three-monthly. A copy of the Internal Audit Schedule was provided to HDC.

i) A session on wound management was delivered at the Heritage Lifecare National Conference in April 2019, which was attended by all the Clinical Services Managers. A further 90-minute wound update was arranged for the Heritage Lifecare Regional Clinical Seminars delivered at eight sites around New Zealand in October/November 2019.

j) Wound care management is included in the annual Heritage Lifecare Limited education calendar, and is scheduled to be provided at least 12-monthly.

k) A case study was developed using this complaint. The case study is to be circulated to all Heritage Lifecare care homes, and managers will be required to share it with their registered and enrolled nursing staff in an education session. The session is to include a facilitated discussion/response to the questions included in the case study. Proof of provision of the education session will be required from all care homes. A copy of the case study was provided to HDC.

Responses to provisional opinion

Mrs B

101. Mrs B was provided with an opportunity to comment on the "information gathered" section of the provisional decision. Where appropriate, her comments have been incorporated into this report. Mrs B told HDC that despite Heritage Lifecare Limited having purchased the rest home fewer than 12 months prior to this incident, she feels that Heritage Lifecare is "playing the blame game". She stated: "[A]ll care homes should have clear policies in place and those policies should have been followed [by its staff]."

Rest home

102. The rest home was provided with an opportunity to comment on the provisional opinion. It told HDC that it accepts the findings in the provisional opinion, and it has started working on the audit of staff compliance, as recommended in the report.

Rest home policies

103. The "Wounds — Assessment and Management" policy (the wounds care policy) stated:

> "Registered Nurses …
>
> - Maintain accurate and comprehensive wound management documentation including photographing wounds as required
> - Adhering to wound management plans, reviewing and amending as clinically required …
>
> The assessment requires the RN to identify the following: date the wound occurred, location and type of wound (see further under Grading Wounds), size, depth and condition of wound ...
>
> Wound management plans must be adhered to …
>
> Monitoring the wound
>
> - Ongoing monitoring and assessments of the wound occurs at each dressing change and will be documented on the wound assessment tool
> - Photographs will be used for complex or slow healing wounds and will be taken weekly as part of the ongoing wound assessment …

Pain assessment

- Pain may be present with many wounds. The presence and nature of pain associated with the wound will be considered each time the wound is dressed or assessed
- Appropriate analgesia will be charted and provided to residents as required
- With large or more complex wounds RN's must consider using analgesia prior to the dressing change (time frames will be agreed with the GP)

Accessing specialist advice

- Healing chronic wounds can present a real challenge for nursing staff and RN's are encouraged to seek expert advice and guidance for their management when they have concerns about slow healing, deteriorating or complex wounds."

104. The "Policy and Procedures on the Management of Pain" (the pain policy) states:

"[A]ll Registered Nurses/Duty Leaders will document in the nursing notes any pain that is experienced by a patient. Any pain which is not able to be controlled by prescribed medication or is acute unexplained pain will be investigated by the Visiting Medical Practitioner …

Procedure for the Management of Pain …

1. Registered Nurses/Duty Leaders will document reported pain on each shift. A pain chart can be used to further document changes, at the request of the management or Clinical Services Manager …

6. Where appropriate, referral to a Pain management Specialist should occur."

105. The "Open Disclosure Policy" states:

"Full and frank information of any resident adverse, unplanned or untoward event is given to all relevant parties …

Management recognises unplanned/adverse events may include any or all of the following:

…

- Unexpected change in resident health status and includes infectious outbreak disease …

Disclosure of information shall be provided in an open, honest, timely and effective manner."

Relevant standards

106. The Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) states:[26]

> "Service Management Te Whakahaere Ratonga
>
> Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> …
>
> Family/whānau participation Urunga Whānau
>
> Standard 2.6 Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals."

Opinion: Heritage Lifecare Limited — breach

Introduction

107. The NZHDSS requires that rest homes ensure that the operation of their services are managed in an efficient and effective manner to ensure that they provide timely, appropriate, and safe services to consumers.[27] The rest home had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and that complied with the NZHDSS and the Code of Health and Disability Services Consumers' Rights (the Code). The rest home was required to have in place adequate systems, policies, and procedures, and to ensure compliance with those policies and procedures, so that the care provided to Mrs A was appropriate, and that any deviations from the standards of care were identified and responded to.

108. Mrs A was let down by various aspects of the care provided to her by numerous staff at the rest home from Month2 to Month6. The rest home advised HDC that from Month2 to Month6, more than 40 staff provided care to Mrs A, or were involved in her care. My expert advisor, RN Rachel Parmee, stated:

> "I do not believe that I can attribute the departures from the required standard of care to any individual providers but rather state that there appeared to be a systemic disregard or ignorance about the communication and clinical responsibilities of the Registered Nurses in their various roles with the notable exception of [RN C] …"

[26] https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf.
[27] NZS 8134.1:2008, Standard 2.2.

109. I agree with this advice. It is apparent that Mrs A was an extremely frail woman who was susceptible to a rapid and significant deterioration. She was vulnerable and dependent on staff to maintain her well-being as far as possible, and keep her comfortable. As such it was extremely important for all aspects of her care to be well planned, with timely interventions delivered consistently by all nursing and support staff. I also note that Heritage Lifecare Limited purchased the rest home fewer than 12 months prior to this incident, and that the rest home was working with staff to embed its quality systems at the time.

110. The rest home stated: "We agree that a number of errors were made in the care of [Mrs A], and that this has served to improve service delivery."

111. This investigation has highlighted that although the various policies and procedures in place at the rest home to guide patient care were in themselves sound, the fact that staff did not follow them consistently meant that service delivery was sub-optimal. The problems that arose with Mrs A's care were not the result of isolated incidents involving one or two staff members, but are attributable to several registered nurses, healthcare assistants, and clinicians who provided care to Mrs A during her stay at the rest home. In my opinion, this indicates failures at a systemic and organisational level. As such, I have found the rest home in breach of the Code for the reasons outlined below.

Wound care

Turning routine

112. Mrs A was on a two-hourly turning regimen from 25 Month1, when two small lesions were discovered on her sacrum. On 14 Month2, it was discovered that Mrs A's lesions had developed into pressure wounds. A Soft Tissue Care Plan completed on 16 Month2 noted that two-hourly turning should be continued.

113. The Turning Chart required rest home staff to initial their name when turning was completed, but this was not done. In Month2, Month3, and Month4, on a significant number of days there were few records of turns in the chart. On some days (eg, 14 and 15 Month2), no turns at all were recorded, and on some days (eg, 6, 7, and 10 Month2, 21 and 27 Month3, and 2 Month4) there were no records from 6am onwards. On 12 Month5, when Mrs A's pressure wound had deteriorated further, turns were not documented in the Turning Chart from 6am to 7pm.

114. Staff statements provided to HDC indicate that some registered nurses could not remember whether Mrs A was turned two hourly all the time. Other nurses stated that Mrs A was turned two hourly but this was not documented, and some nurses said that they directed the care staff to turn Mrs A every two hours and to document turns in the notes.

115. The rest home's RCA report noted that "turning charts were not consistently completed when Mrs A was turned and or mobilised".

116. RN Parmee advised:

> "To prevent further injury [Mrs A] required management of her incontinence to maintain skin integrity and regular changes of position while in bed and up in a chair … However, the turning charts were not completed according to the template instructions. They were not initialled or toileting comments included, nor were changes in position while [Mrs A] was up in a chair noted."

117. I am very concerned that over a number of days there were no records of turns in the Turning Chart. I am unable to determine whether the lack of records indicates that Mrs A was not turned on these days, or whether she was turned but this was not documented. In any event, I am critical that the turns were not documented appropriately over a three-month period, and that staff did not follow the instructions on the Turning Chart by initialling their name or documenting when Mrs A attended the toilet.

Soft Tissue Care Plans

118. The first Soft Tissue Care Plan, completed on 16 Month2, stated that the stage of the pressure injury should be circled and the skin tear categorised as per the STAR Skin Tear Classification. This was not done. The plan also provided for descriptions for evaluation, but these were not noted on the form consistently (eg, temperature and pain were not always included).

119. On 6 Month4, the DHB's wound care nurse and HealthCERT were notified of Mrs A's stage 3 pressure wound. Another Soft Tissue Care Plan was completed, but the pressure wound was noted on the form as a stage 2 wound. This was the first staging of the wound on the Soft Tissue Care Plan, and rest home staff did not complete the STAR Skin Tear Classification. On 18 Month4, the wound was updated to stage 3 on the plan, but again staff did not complete the STAR Skin Tear Classification — this was completed only on the final Soft Tissue Care Plan form on 2 Month6.

120. The rest home's RCA report stated that there is no documented evidence available to indicate that the pressure injury was staged in the period of 16 Month2 to 6 Month4.

121. RN Parmee advised:

> "This indicates that the stage of the wound was not accurately recorded on the care plan at the time. This makes it difficult to assess the timeliness of interventions and reporting … It appears that the appropriate tools for assessment and monitoring were available for staff to use but there appears to be a lack of consistency and accuracy in their use."

122. I agree, and am critical that the Soft Tissue Care Plans were not completed appropriately by several staff at the rest home.

Dressing changes

123. On 6 Month4, the progress notes record that Mrs A's dressing needed to be changed daily. On 26 Month4 (after Dr F's review), the progress notes again document that Mrs A needed to have wound care each day after her shower or wash. However, on several days Mrs A's dressing was not changed, and instead it was noted by staff that the dressing was still intact. On some days, staff did not record anything at all about the dressing.

124. I am critical that Mrs A's dressing was not changed daily in accordance with the progress notes and Dr F's review.

Referral to wound care specialist

125. RN D, the DHB wound care nurse specialist, was first contacted by RN C on 6 Month4 about Mrs A's pressure wound, and informed that it was a stage 3 wound. RN D was then contacted again on 14 Month5 and 31 Month5. RN D was to assess the wound in person on 13 Month6, but this did not occur, as Mrs A had passed away.

126. Dr F first reviewed Mrs A's wounds on 26 Month4. The rest home's nursing staff did not initiate the review, but rather it was a routine three-monthly GP review. Dr F noted that healing would be impaired because of Mrs A's cachexia and lack of mobility, and he prescribed pain medication.

127. The rest home's RCA report stated that there were delays in seeking medical review, and that there was limited access to specialist nursing support.

128. RN Parmee opined:

> "I believe there was a severe departure in terms of the timeliness of interventions and notifications related to lack of consistency of assessment and documentation as described above. Given the very high risk for [Mrs A] to develop pressure injuries that would be difficult to heal, I believe consultation with the wound care specialist with regard to management of the wound and the GP with regard to nutrition and pain relief should have occurred on discovery of the pressure injury or soon after rather than nearly two months later."

129. I accept RN Parmee's advice. I am critical that the rest home's nursing staff did not seek assistance from the wound care specialist or the GP earlier.

Compliance with wounds policy

130. The rest home's wounds policy stated that registered nurses should maintain accurate and comprehensive documentation, including photographs of wounds as required, and should adhere to wound management plans. The wounds policy also stated that registered nurses should identify and document the type, size, depth, and condition of the wound.

131. As discussed above, rest home staff did not change Mrs A's dressing daily, and there is no documented evidence that she was turned consistently every two hours. There was also a

lack of appropriate documentation in the Turning Charts and Soft Tissue Care Plans about the stage, size, and condition of Mrs A's wound.

132. The rest home's RCA report stated:

> "Care staff did not fully comply with all Heritage Lifecare policies, procedures and processes … There was also a lack of consistency in the use of the correct assessment and monitoring tools, and not all documents were completed correctly as per [Heritage Lifecare] policy."

133. The wounds policy also stated that photographs should be taken weekly as part of ongoing wound assessment for complex or slow-healing wounds. Photographs of Mrs A's wound were taken only monthly from Month4 to Month5.

134. As RN Parmee noted: "At this stage the wound had been present and deteriorating for 2 months. Photographs should have been taken earlier and more regularly."

135. RN Parmee also advised:

> "I believe there has been a severe departure from the standard of care in terms of accuracy of documentation which in turn led to delays in reporting and interventions … The provided wound assessment and management policy states that the registered nurses are responsible for maintaining accurate and comprehensive wound management documentation … This policy appears not to have been followed as evidenced by the documentation provided.
>
> It appears that the appropriate tools for assessment and monitoring were available for staff to use but there appears to be a lack of consistency and accuracy in their use."

136. I agree with RN Parmee. I am critical that the rest home's wounds policy was not followed by its staff, and that staff did not document the progress of the wound appropriately, including photographing the wound at appropriate intervals, as required by the policy. It is clear that staff did not comply with the rest home's wounds policy.

Pain management

Pain assessments

137. The rest home's wounds policy states that the presence and nature of the pain associated with a wound is to be considered each time the wound is dressed or assessed. The Soft Tissue Care Plan also included pain as one of the descriptions for evaluation.

138. The Soft Tissue Care Plan was first completed on 16 Month2, but Mrs A's pain levels were not documented until 28 Month3, when it was recorded that she was experiencing no pain. On 9 Month4, staff first noted in the Soft Tissue Care Plan that Mrs A felt pain when the wounds were cleaned or touched. Despite this, a Pain Chart was not started, and Mrs A was not referred to a GP to assess the pain further.

139. A Pain Chart was first used on 22 Month5. The Abbey Pain Scale was then used from 24 Month5, following Dr F's advice that this should be used instead of the normal pain chart.

140. RN Parmee advised that "on review of the documents provided it appears that [the wounds] policy was not followed in Mrs A's case". She also advised:

> "Given that [Mrs A] had advanced dementia it would have been difficult to assess her pain using an analogue pain scale such as used between the 22nd and 24th [Month5]. The Abbey pain scale commenced on the 24th [Month5] was more appropriate."

141. I accept RN Parmee's advice. I agree that from the outset the Abbey Pain Scale should have been used by the rest home's nursing staff, rather than an analogue pain scale, given that Mrs A had dementia. The first pain assessment occurred six weeks after the discovery of the pressure wound, and Mrs A's pain was not assessed at every wound dressing in accordance with the wounds policy. I am critical of the delay in commencing any pain assessment after the discovery of Mrs A's wounds, and that the wounds policy was not followed in relation to pain management. This further illustrates the systemic failure by rest home staff to follow its own wounds policy and use the available assessment tools appropriately.

Pain relief

142. On 26 Month4, Dr F reviewed Mrs A, as per his three-monthly GP review, and prescribed regular morphine. Dr F also noted that Mrs A felt pain when her dressing was changed. Prior to this review, the nursing staff had not sought any assistance or advice from the GP about her pain management.

143. According to the medication chart, Mrs A was first prescribed PRN morphine on 3 Month5. The PRN morphine was not administered prior to Mrs A's dressing change until 11 days later, on 14 Month5. On 24 Month5, Dr F reviewed Mrs A again. He increased her regular morphine prescription to four times a day, and also prescribed further PRN injectable morphine. Mrs A's family told HDC that on several occasions they had to ask the nurse to give Mrs A more morphine, as they could see that she was in pain. According to the Medications Administration Records, Mrs A was given PRN morphine prior to a dressing change on 28 and 29 Month5.

144. The wounds policy states that with large or more complex wounds, registered nurses must consider using analgesia prior to a dressing change. The pain policy also states that where appropriate, referral to a pain management specialist should occur.

145. RN Parmee advised:

> "I believe that the delays in commencing assessment and management of [Mrs A's] pain constitute a severe departure from the standard of care. The institution's wound care policy in relation to pain management was not followed … The GP was not notified early enough to chart regular and PRN Morphine. The PRN Morphine was not used consistently for dressing changes as stated in the policy."

146. I accept RN Parmee's advice in relation to the management of Mrs A's pain, and I am critical that the rest home did not manage Mrs A's pain appropriately.

Conclusion

147. In summary, I find that the rest home did not provide appropriate care and services to Mrs A for her pressure wound for the following reasons:

a) There is no documented evidence that she was turned every two hours, and staff did not follow the instructions on the Turning Chart;

b) Her wound dressing was not changed daily;

c) The Soft Tissue Care Plan was not completed appropriately;

d) Documentation by rest home staff was poor;

e) The wounds care policy was not followed;

f) There were delays in seeking medical and/or specialist review of the wounds;

g) Mrs A's pain management associated with her wound was inadequate because:

i. There were delays in the assessment of her pain;

ii. The initial choice of pain assessment tool was not appropriate;

iii. The wounds care (in relation to pain management) and pain policies were not followed;

iv. PRN morphine was not used consistently when Mrs A's dressing was changed; and

v. There was a delay in seeking advice or assistance from the GP about Mrs A's pain.

148. As a consequence, Mrs A's pressure wounds and resulting pain were not assessed and responded to appropriately, and her wounds continued to deteriorate. Accordingly, I find that the rest home breached Right 4(1) of the Code.[28]

Communication with family — adverse comment

149. Mrs A's daughters held an EPOA for their mother. According to the progress notes, Mrs A's family was first informed about the pressure wound on 23 Month2 (around a week after the wound was discovered). Mrs A's wounds continued to deteriorate from this time, but her family was not provided with any further update about this until 20 Month5. Mrs B told HDC that she was informed about the wound only because she happened to visit her mother when staff were changing the dressing.

150. The rest home's Open Disclosure Policy states that full and frank information should be given to all relevant parties, and that this includes an unexpected change in a resident's health status.

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

151. The rest home accepted that Mrs A's family was not informed about the progress of her wounds, and apologised for the lack of communication.

152. By Month4, Mrs A's wounds had already deteriorated to level 3, and this was serious enough to warrant notification to HealthCERT. I am critical that the rest home did not keep the family updated and fully informed of Mrs A's deteriorating wounds.

Management of staff — adverse comment

153. From Month2, the Clinical Services Manager, RN M, was seconded to another rest home, and in Month5 she was moved permanently to another rest home. The Quality Coordinator, RN N, said that she had to manage the GP rounds because the Clinical Services Manager had been seconded to another site from Month2. RN C started her role as a senior nurse from 12 Month3, and became the interim Clinical Services Manager on 30 Month4. According to RN L, RN C took over the Clinical Services Manager role in "everything but name". However, RN C told HDC that she was not asked to pick up the Clinical Services Manager role until late Month4.

154. Given the above evidence, it is not clear who had the responsibility of the Clinical Services Manager role from Month2 until the end of Month4.

155. RN Parmee stated: "There appears to be a lack of adherence to communication responsibilities with regard to the reporting and response to clinical management concerns." She also provided an example of policies that required Clinical Services Manager input, and stated:

> "Of major concern is the inconsistency in following the Pain management policy which clearly states that a pain management chart can be used to document changes at the request of the Clinical Services Manager."

156. I am concerned by the lack of clear guidance as to who had the overall responsibility of the Clinical Services Manager role at the rest home, particularly from Month2 to Month4. This more than likely contributed to the lack of clinical guidance and management of Mrs A's wounds during this period.

Recommendations

157. I note that since this incident, the rest home has made several changes to its service. Nevertheless, in light of this complaint and the findings made, I recommend that Heritage Lifecare Limited:

a) Provide a written apology to Mrs A's family for the breach of the Code 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 B.

b) Conduct an audit of staff compliance with the following policies for the preceding four months from the date of this report:

   i. The wounds care policy;

   ii. The pain policy; and

   iii. The open disclosure policy.

   The results of the audit are to be reported to HDC within six months of the date of this report. Where the audit results do not show 100% compliance, the rest home is to advise what further steps will be taken to address the issue and undertake a further audit to confirm compliance.

c) Conduct a random audit of wound documentation for ten residents over the past six months, to ensure compliance with relevant rest home policies. The rest home is to report the results of the audit to HDC within six months of the date of this report. Where the audit results do not show 100% compliance, the rest home is to advise what further steps will be taken to address the issue and undertake a further audit to confirm compliance.

d) Report back to HDC regarding the implementation and effectiveness of the changes stated at paragraph 100 of this report, within six months of the date of this report.

Follow-up actions

158. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Heritage Lifecare Group Limited, will be sent to HealthCERT (Ministry of Health) and the DHB, and they will be advised of the name of the rest home.

159. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Heritage Lifecare Group Limited, will be sent to the New Zealand Aged Care Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rachel Parmee:

"1.Thank you for the request to provide clinical advice regarding the complaint from [Mrs B] in relation to the care of her late mother [Mrs A] at [the rest home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

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

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] at [the rest home] was reasonable in the circumstances and why, with particular comment on:

   a. The overall management and care of [Mrs A's] pressure wound

   b. Whether [the rest home] appropriately organised for [Mrs A's] pressure wound to be reviewed by senior medical staff, including the doctor and wound care specialist.

   c. The adequacy of [Mrs A's] pain assessment and management.

   d. Any other matters that I consider warrant comment.

For each question I am asked to advise:

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

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

c. How would it be viewed by my peers?

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

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

    1. Letter of complaint dated …
    2. [The rest home's] letter of response dated …
    3. [Mrs A's] clinical records, covering the period from [Month2] to 12 [Month6].
    4. Correspondence between [the rest home] and [RN D], Wound Care Specialist at [the DHB].
    5. Correspondence between [the rest home] and the EPOA/family.
    6. [The rest home's] policy regarding wound care.

5. Background

[Mrs B] is raising concerns about the care provided to her late mother, [Mrs A], at [the rest home] where she resided. [Mrs A] suffered from dementia.

A pressure wound developed on [Mrs A's] sacrum in [Month2].

[The rest home] initially used their standard pain assessment chart to assess [Mrs A's] pain, however the Abbey Pain Assessment Scale was commenced on 24 [Month5].

The wound care specialist was first contacted on 6 [Month4] and was due to assess [Mrs A] in person on 13 [Month6]. However [Mrs A] died on 12 [Month6].

Review of Documents

6. The overall management and care of [Mrs A's] pressure wound

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

Accepted practice around the management and care of pressure wounds includes appropriate and timely assessment, planning, intervention and evaluation. The information provided includes documentation related to these stages but is not always accurate or adequate.

In terms of assessment, the InterRAI Outcome Scales (dated 28th [Month5]) indicate that [Mrs A] was at very high risk for ongoing complications of her existing pressure wounds. She had a low BMI indicating ineffective nutrition. She scored highly for pain

and low for communication and cognitive performance and very low for activities of daily living. The InterRAI Clinical Assessment Protocol manual (2010) lists intrinsic risk factors for pressure injuries as altered mental status (e.g. dementia) immobility, incontinence, poor nutrition and inactivity. [Mrs A] presented all of these risk factors which needed to be considered when planning care. The Norton Pressure Area Risk Scale (commenced on the 16th [Month2] when the pressure injury was first noticed) consistently scores 10 and then 9 over subsequent months. A score less than 14 indicates that the patient is at risk. These assessments indicate that [Mrs A] was compromised in terms of healing, ability to articulate pain and ability to prevent ongoing complications through mobility and changes of position.

In her letter [RN L] (Facility Manager), provides an excellent list of measures to prevent the development of pressure injuries (point 7). While these measures are appropriate in the prevention of pressure injuries there is no careplan which lists these interventions, nor is there daily reference to these measures in the progress notes.

The appropriate environment for pressure injury healing includes prevention of further injury, adequate nutrition and pain relief. To prevent further injury [Mrs A] required management of her incontinence to maintain skin integrity and regular changes of position while in bed and up in a chair. [Mrs A] was provided with appropriate pressure relieving devices — i.e. a Posture-Temp pressure relieving cushion and replacement of the standard Elite 1000 Areia mattress with an Areia 8 Dynamic alternating mattress replacement system on 22nd [Month3]. She was on a turning regime (commenced on 26th [Month1] prior to the discovery of her pressure injury). However, the turning charts were not completed according to the template instructions. They were not initialled or toileting comments included, nor were changes in position while [Mrs A] was up in a chair noted. Grey, Harding and Enoch (2006) state that when sitting in a chair a patient at risk of pressure ulcers, while using a pressure relieving cushion, should be encouraged to shift position every 15–30 minutes. If they are unable to do this independently they should be repositioned at least hourly.

The nutrition profile and assessments provided are inconsistent with the InterRAI assessment and GP assessments. Assessments completed on [two occasions] give scores of 26 and 22 respectively which indicate low risk and have circled 4 which indicates usual weight and steady, usual appetite, able to eat and drink independently, uncomplicated medical condition and Grade 0 to 1 pressure sore. GP notes indicate on [date] that [Mrs A's] weight was heading down and on 17 [Month1] and 26 [Month4] [Mrs A] had advanced cachexia (weakness and wasting of the body due to severe chronic illness).

This assessment indicates the complete opposite of [Mrs A's] nutritional status compared with the GP assessment and her level of dependence and advanced dementia. Clearly there has been an error in completing the forms which does not help with providing accurate documentation nor does it meet its purpose of providing

assessment information to be used in planning care. However, [Mrs A's] diet was in fact consistent with attempting to meet her nutrition and therefore healing needs with the commencement of a high protein diet on the 22nd [Month2] and addition of Complan on 22nd [Month5].

It was first noted that [Mrs A] had a pressure wound on her sacrum on 16th [Month2]. The Soft Tissue Careplan commenced that day does not have the stage of the pressure injury circled. It states the dressing used and there is some evaluation of the wound, however not all categories of the descriptors are used, such as size, pain, colour all important aspects of wound evaluation. The Soft Tissue Careplan commenced on 06 [Month4] uses the prescribed format for 3 days. The plan commencing 18 [Month4] changes the stage of the wound from 2 to 3.

The wound was reported to HealthCERT on 06 [Month4] and would need to have been at stage 3 to necessitate reporting. This indicates that the stage of the wound was not accurately recorded on the careplan at this time. This makes it difficult to assess the timeliness of interventions and reporting.

While there were inaccuracies and inconsistencies in documentation the Soft Tissue Careplan does contain clear instructions and records of dressings used. Photographs including measurements were taken monthly from [Month4] alongside consultation with the wound care nurse specialist. The Institution's wound management policy states that photographs of complex or slow healing wounds should be taken weekly. At this stage the wound had been present and deteriorating for 2 months. Photographs should have been taken earlier and more regularly.

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

I believe there has been a severe departure from the standard of care in terms of accuracy of documentation which in turn led to delays in reporting and interventions such as changes to diet, reporting to GP and wound care specialist. The provided wound assessment and management policy states that registered nurses are responsible for maintaining accurate and comprehensive wound management documentation including photographing wounds (weekly for complex or slow healing wounds) using the pressure area grading system and noting the condition of the wound bed, signs of infection, presence of odour and exudate and wound margins. This policy appears not to have been followed as evidenced by the documentation provided.

It appears that the appropriate tools for assessment and monitoring were available for staff to use but there appears to be a lack of consistency and accuracy in their use. From the correspondence with the wound care nurse it appears that [Mrs A's] complex wound was being managed appropriately and her advice was being followed. In her letter [RN L] acknowledges the need for further education in documentation and pressure relieving equipment and earlier contact with the wound care nurse.

c. How would it be viewed by your peers?

I believe my peers would agree with my finding.

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

[RN L] has, I believe, provided a list of corrective actions which would prevent a similar occurrence in the future. Of particular relevance to the management and care of pressure injuries are:

- Instigation of a Primary Nursing system which gives one nurse ultimate responsibility for each resident. This would ensure that planning, interventions and documentation are consistent.
- Clinical Manager to review all wounds at least twice weekly, again providing consistency and expert input.
- Each registered nurse to [receive] an education session on Pressure Area Management.
- Education on pressure relieving equipment and appropriate use.

7. Whether [the rest home] appropriately organised for [Mrs A's] pressure wound to be reviewed by senior medical staff, including the doctor and wound care specialist

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

The Heritage Lifecare policy on Wound Assessment and Management states that all wounds that are two months or older should be reviewed by a wound specialist or GP.

The wound care specialist was contacted on 6th [Month4] when [Mrs A's] wound was described as a stage 3 sacral pressure injury. The notification to HealthCERT was made on this day and notes that a wound specialist had assessed the wound. The wound care specialist was contacted 3 weeks later (14th [Month5]) when the wound had increased in size. The wound care specialist was contacted again on the 31st [Month5] after the wound had deteriorated significantly. At this point it was arranged for the wound care specialist to see the wound in person.

The GP ([Dr F]) noted the presence of [Mrs A's] pressure injury on 26th [Month4], acknowledging that healing would be difficult given [Mrs A's] cachexia, immobility and dementia. The consultation was a routine 3 monthly review rather than a consultation initiated by nursing staff in the light of [Mrs A's] deteriorating condition.

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

I believe there was a severe departure in terms of the timeliness of interventions and notifications related to lack of consistency of assessment and documentation as described above. Given the very high risk for [Mrs A] to develop pressure injuries that

would be difficult to heal, I believe consultation with the wound care specialist with regard to management of the wound and the GP with regard to nutrition and pain relief should have occurred on discovery of the pressure injury or soon after rather than nearly two months later. The policy criteria of two months for such notification was met but the circumstances and rapid deterioration of the wound required earlier intervention.

c. How would it be viewed by my peers?

I believe my peers would agree with this view.

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

[RN L] has provided a list of corrective actions which I believe would prevent a similar occurrence in the future. Of particular relevance to the timeliness of review by GP/Wound Care specialist are:

- Early involvement of Wound Care Specialist
- Clinical manager must review all wounds twice weekly

8. The adequacy of [Mrs A's] pain assessment and management.

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

The standard of care in relation to pain assessment and management requires appropriate assessment of pain and interventions that are evaluated each time.

The Heritage Lifecare policy on Wound Assessment and Management states that the presence and nature of pain associated with the wound will be considered each time the wound is dressed or assessed, appropriate analgesia will be charted and provided to the resident as required and with large and more complex wounds RNs will consider using analgesia prior to the dressing change. On review of the documents provided it appears that this policy was not followed in [Mrs A's] case.

The Soft Tissue Care plan (commenced on discovery of [Mrs A's] pressure injury on 16th [Month2]) first mentions pain assessment on the 28th [Month3], stating no pain. On the 24th [Month4] there is mention of pain on touch. Therefore, according to the documentation pain was not assessed until some 6 weeks after the wound was discovered.

It was not until the 22nd [Month5] that the use of a pain assessment tool was commenced. Given that [Mrs A] had advanced dementia it would have been difficult to assess her pain using an analogue pain scale such as that used between the 22nd and 24th [Month5]. The Abbey pain scale commenced on the 24th [Month5] was more appropriate. Documentation provided showed consistently low pain scores using the Abbey pain scale. This could have been related to the skill of those using the tool. Brown (2011) states that, as with all pain assessment tools, the Abbey Pain Scale

has limitations. In particular it does not distinguish between distress and pain and it is reliant upon the nursing staff's interpretation of what the patient is experiencing.

[Mrs A] had advanced dementia. Studies have shown that pain is under reported and undertreated in elderly and particularly those with dementia. Horgas and Tsai (1998) summarise their findings by stating that cognitively impaired nursing home residents are prescribed and administered significantly less analgesic medication, both in number and in dosage of pain drugs than their more cognitively intact peers. In multiple regression analyses holding the presence of painful conditions constant, more disoriented and withdrawn residents were prescribed significantly less analgesia by physicians; more disoriented, withdrawn, and functionally impaired residents were administered significantly less analgesia by nursing staff. These findings are reflected, I believe, in the management and treatment of [Mrs A's] pain.

According to Medimap records [Dr F] charted 5mg of Morphine 4 times a day for pain associated with her wound, during the routine 3 monthly review on 26th [Month4]. This was also the first time [Mrs A's] wound was reviewed by [Dr F]. PRN Morphine (as required) was not charted until 3rd [Month5].

According to administration records PRN Morphine administered prior to dressing changes was administered for the first time on 14th [Month5]. This was then given 16 times between 14th of [Month5] and 11th [Month6] when [Mrs A] was commenced on a syringe driver for terminal care.

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

I believe that the delays in commencing assessment and management of [Mrs A's] pain constitute a severe departure from the standard of care. The institution's wound care policy in relation to pain management was not followed. There is inconsistency between the Soft Tissue Care plan and recordings on the Abbey Pain Scale. The GP was not notified early enough to chart regular and PRN Morphine. The PRN Morphine was not used consistently for dressing changes as stated in the policy. This is consistent with [Mrs A's] daughter's contention that they needed to remind staff to administer pain relief prior to dressing changes.

c. How would it be viewed by your peers?

My peers would, I believe, agree with my findings.

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

In her letter [RN L] acknowledges the need for education in pain management. In conjunction with this there needs to be education related to pain assessment and management in relation to dementia and the need to synchronise wound assessment,

pain assessment and medication in a timely manner. The proposed implementation of Primary Nursing would assist this process.

9. Any other matters that I consider warrant comment.

Two points made by [RN L] in her response warrant comment. These are the delay in facilitating viewing [Mrs A's] notes and presence of nursing staff during this process, and the change in the time of [Mrs A's] dressing.

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

Accepted practice is that when relatives or residents request to see their notes an appointment is made and nursing staff are present to answer questions related to the information in the notes.

It appears that the decision to do [Mrs A's] dressing early in the day in conjunction with her daily cares is in accordance with accepted practice as [RN L] states.

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

There is no departure from accepted practice in either of these instances.

c. How would it be viewed by your peers?

My peers would, I believe, agree with my findings.

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

No recommendations are required.

References

Brown, D. (2011). Pain Assessment with Cognitively Impaired Older People in the Acute Hospital Setting. *Reviews in Pain, 5*(3), 18–22.
Doi: 10.1177/204946371100500305

Grey, J. E., Harding, K. G., & Enoch, S. (2006). Pressure ulcers. BMJ (Clinical research ed.), 332(7539), 472–5.

Horgas, A. L., & Tsai, P. (1998). Analgesic Drug Prescription and Use in Cognitively Impaired Nursing Home Residents. Nursing Research, 47(4), 235–242.
Doi: 10.1097/00006199-199807000-00009

Morris, J. and Belleville-Taylor, P. (2010). InterRAI clinical assessment protocols (CAPs) for use with community and long-term care assessment instruments. 9th ed. Washington, DC: InterRAI."

The following further expert advice was obtained from RN Parmee:

> "Thank you for the opportunity to provide further advice in relation to case C18HDC01213 for which I provided an initial report on 23rd December 2018.
>
> I have utilised the following information for my review:
>
> 1. My initial expert advice report
> 2. Documents obtained since my initial advice:
>
> - Response from [the] Heritage Lifecare General Manger, Clinical and Quality
> - [The rest home's] Clinical Handover forms with reference to [Mrs A]
> - Root Cause Analysis Report in relation to the care of [Mrs A]
> - Responses from staff to questions related to HDC complaint
>
> [RN M] — Clinical Services Manager
> [RN L] — Facility and Care Home Manager
> [RN N] — Quality Co-ordinator
> [RN I] — Registered Nurse
> [RN G] — Registered Nurse
> [RN H] — Registered Nurse
> [RN O] — Registered Nurse
> [RN C] — Clinical Manager
> [RN J] — Registered Nurse
> [RN E] — Registered Nurse
>
> - Job descriptions of staff involved in [Mrs A's] care
> - Heritage Lifecare policies related to
>
> Open Disclosure
> Guidelines for communication with residents, relatives and visitors
> Information, communication and language policy
> Pain management
> Clinical Handover
> Deterioration in Health Status Procedure
> Procedure for contacting doctor
>
> - Records and content of staff training sessions
> - Audit tools and schedules
> - Case study based on HDC complaint
> - Emailed statements from [RN E] and [RN J] (both Registered Nurses)

I am asked to advise:

1) Whether any of the information contained in the response from Heritage Lifecare causes me to change my initial advice.

My initial advice considered the following:

a) The overall management and care of [Mrs A's] pressure wound

b) Whether [the rest home] appropriately organised for [Mrs A's] pressure wound to be reviewed by senior medical staff, including the doctor and wound care specialist.

c) The adequacy of [Mrs A's] pain assessment and management.

The Root Cause Analysis Report supports my findings around issues of care planning, appropriate intervention and documentation. There is nothing in the information provided to prompt me to change my initial advice in each of these areas.

As I commented in my initial report appropriate policies were in place but not followed.

I note that the policies included in the documentation were all reviewed in 2017 prior to these events.

Again, I state that while the policies were adequate they were not followed in the care of [Mrs A].

This is borne out by the statements of Registered Nurses involved in [Mrs A's] care.

2) Whether I would attribute any departures from the required standard of care to any individual providers involved in [Mrs A's] care.

It appears from the responses made by senior nurses that they were in contradiction of the requirements of their job descriptions. For example:

1) The Facility Manager job description key objectives include: provide leadership including clinical supervision, assist and support Clinical Services Manager (CSM) and senior Registered Nurse in the effective clinical management of the facility, monitor the provision of care to residents, provide oversight of all residential records and recordings to ensure they meet organisational and legislative requirements.

   In her statement [RN L], who was Facility Manager at the time, states that while she spoke daily with the Clinical Services Manager for an update on residents' conditions she was not advised of [Mrs A's] deteriorating condition. She also stated that she spoke with RNs on multiple occasions to ensure that care matched the careplan and that recordings were accurate and timely.

2) The CSM job description key objectives include: provide leadership and clinical supervision to all clinical and care staff, monitor the provision of care to residents to ensure that the highest standards are achieved and maintained and meet contractual and best practice requirements, provide oversight of all residential records and recordings to ensure they meet organisational and legislative requirements and demonstrate commitment to a safe environment for all residents and staff.

   In her statement [RN M], who was Clinical Services Manager at the time states that she did not provide care for [Mrs A] and was not involved in any assessment of [Mrs A] or aware of her wounds.

3) [RN N] was Quality Co-ordinator and had the responsibility of managing GP rounds while the CSM was seconded to another site. The relevant responsibility in the Quality Manager job description is to act as resource person. This included documentation of GP orders and then handover to RN to carry these out. She states she did [Mrs A's] dressing once following wound care specialist guidelines and did not provide additional pain relief at the time of the dressing.

4) The relevant Registered Nurse (RN) job description key responsibilities include: effective team leadership, follow policies and procedures in all matters, provide competent professional clinical practice within the legislation, ensure quality resident care is carried out based on set standards and the policies and procedures of the facility, provides a safe caring environment for all residents and staff.

The statements of [RN I], [RN G], [RN H], [RN O] and [RN C], [RN E] and [RN J] were provided.

[RN I] provides the dates when she changed [Mrs A's] dressing and that she gave pain relief prior to the dressing change. She states that she had regular communication and a good rapport with [Mrs A's] family. She says she discussed reporting of the wound to the CSM and accepts that a pain chart should have been commenced and the turning chart completed.

[RN G] also did [Mrs A's] dressing and provided pain relief prior to the dressing change. She also states that a pain chart should have been commenced and turns documented.

[RN H] worked night shift and did not do [Mrs A's] dressing or have involvement in her care planning, and believes [Mrs A's] turning schedule was adhered to. She also agrees that a pain chart should have been implemented.

[RN O] worked afternoon shifts and changed the dressing once without prior pain relief. She was also not involved in planning wound care.

[RN C] was interim Clinical Services Manager. She states that she initiated the process of reporting [Mrs A's] wound as soon as she was aware of it. The report was referred to the Quality Team and Clinical Services Manager ([RN M]). Evidence is also provided of [RN C's] initiation of pressure relieving measures and dietary supplementation.

[RN E] and [RN J] both summarise the need for turns and pain assessment but concede that documentation was not always consistent. [RN E] mentions consultation with the clinical manager, facility manager and quality manager and the undertaking that a wound specialist would be involved. This contradicts statements that these senior staff were not involved in [Mrs A's] care or had knowledge of her deteriorating condition.

There appears to be a lack of adherence to communication responsibilities with regard to the reporting and response to clinical management concerns. I believe the Facility Manager and CSM should have been aware of [Mrs A's] wounds and deteriorating condition. I note in particular [RN C's] concern that the wound had not been reported prior to her becoming aware of it. Of major concern is the inconsistency in following the Pain management policy which clearly states that a pain management chart can be used to document changes at the request of the Clinical Services Manager. In this case the RNs all agree that such documentation should have been in place. Therefore, the clinical services and facility managers should have been aware of [Mrs A's] pain and deteriorating condition in order for this to take place.

In conclusion, I do not believe that I can attribute the departures from the required standard of care to any individual providers but rather state that there appeared to be a systemic disregard or ignorance about the communication and clinical responsibilities of the Registered Nurses in their various roles with the notable exception of [RN C] as discussed above.

This lack of communication and responsibility is reflected in my initial findings around inadequate care planning, appropriate intervention and documentation.

Please do not hesitate to contact me if further clarification is required.

Yours sincerely

Rachel Parmee"