Te Whatu Ora Tairāwhiti |Health New Zealand

A Report by the

Aged Care Commissioner

(Case 19HDC02091)

Contents

Executive summary 1

Complaint and investigation 2

Information gathered during investigation 2

Opinion: Te Whatu Ora Tairāwhiti — breach..14

Changes made 23

Recommendations..24

Follow-up actions 26

Appendix A: Independent clinical advice to Commissioner 27

Executive summary

1. An elderly man was an inpatient at Gisborne Hospital in 2019. He was suffering from sepsis and chronic wounds in his big toe and heel as a result of reduced blood flow. This report examines the nursing care he received on two wards at Gisborne Hospital, and identifies a number of inadequacies in that care, stemming from systemic failings at Te Whatu Ora|Health New Zealand Tairāwhiti (Te Whatu Ora) (formerly known as Tairāwhiti District Health Board). Sadly, the man died a short time later.

Findings

2. The Aged Care Commissioner identified a number of shortcomings at Gisborne Hospital that resulted in inadequate nursing care being provided to the man. Those included, that there was little evidence of coordination between multi-disciplinary team members and the family, wound management and documentation of wound care was inadequate, incontinence was not managed appropriately, nutrition and weight monitoring was inadequate, cracked and defective food trays were used on the wards, a head wound suffered by the man was not investigated adequately, and his condition was not subsequently monitored appropriately. The Aged Care Commissioner identified that these failures constituted departures from the standard of care and found that Te Whatu Ora had breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

3. The Aged Care Commissioner also raised concerns about tidiness and hygiene standards on the wards at Gisborne Hospital and reminded Te Whatu Ora of their responsibilities in respect of appropriate uniform standards, tidiness and cleanliness.

4. The Aged Care Commissioner also identified an issue with unclear recording of analgesic administration and pain scores and noted that it would have been more appropriate for Te Whatu Ora to use a numerical pain score.

Recommendations

5. The Aged Care Commissioner recommended that Te Whatu Ora apologise to Mr A's family.

6. In addition, systems improvement recommendations made by the Aged Care Commissioner included; a review of Te Whatu Ora's health and safety, housekeeping, and infection control audits and tools, confirming implementation of a replacement programme for over-the-bed tables and auditing the condition of patient equipment on the wards, auditing the proper use of the nutrition and hydration sections of the patient care plan, auditing the proper management of unexplained injuries on the wards, considering developing a tool to document multi-disciplinary team meetings, reviewing its wound management assessment and monitoring tools against international standards, reporting to HDC on a review of its pain management programme, carrying out a baseline audit of continence assessments and corresponding care plans, and reporting to HDC on a planned review of its nursing documentation.

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Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Te Whatu Ora|Health New Zealand Tairāwhiti[1] (Te Whatu Ora), formerly known as Tairāwhiti District Health Board (Tairāwhiti DHB), to her father, Mr A. The complaint was made on behalf of Mr A's wife and children. Sadly, Mr A died. I extend my condolences to Mr A's family. The following issue was identified for investigation:

- *Whether Hauora Tairāwhiti District Health Board provided Mr A with an appropriate standard of care between Month1[2] and Month3 2019 (inclusive).*

8. This report is the opinion of Aged Care Commissioner Carolyn Cooper and is made in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Ms B (on behalf of the family)	Complainant/daughter
Te Whatu Ora	Provider

10. Senior Te Whatu Ora employee Ms C is also mentioned in this report.

11. Further information was received from ACC and Waikato Hospital.

12. Independent advice was obtained from a nurse practitioner, Ms Stephanie Thomson (Appendix A).

Information gathered during investigation

Background

13. Mr A was aged in his eighties at the time of events. He had a history of reduced blood flow[3] in his legs (resulting in amputation of his left big toe), skin infections in his legs, diabetes, stomach ulcers, arthritis, high blood pressure, and a blood clot in his lung[4] following a knee replacement. This report relates to the care he received by Te Whatu Ora as an inpatient on two wards at Gisborne Hospital between Month1 and Month3.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to Hauora Tairāwhiti or Tairāwhiti DHB now refer to Te Whatu Ora Tairāwhiti.

[2] Relevant months are referred to as Months 1-3 to protect privacy.

[3] Ischaemia.

[4] Pulmonary embolism.

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Clinical progression

First admission to Gisborne Hospital

14. Mr A had been suffering from dementia symptoms for some time. In the week preceding his admission to Gisborne Hospital, Mr A's family had noticed that his dementia-like symptoms seemed to be worsening, and he was sleeping more, he was less mobile, and he was agitated during the night. On the day of his admission, he also developed a cough.

15. Mr A was admitted to Gisborne Hospital on 6 Month1. He was found to have sepsis, a serious complication arising from the chest and urinary infections he was suffering.[5] He was treated with antibiotics, and the infections subsided.

16. On 8 Month1, Mr A was referred to the surgical team for a review of the chronic wounds in his right big toe and heel. Swabs showed infection with *Pseudomonas aeruginosa* and *Staphylococcus aureus*.[6] Consideration was given to amputating the toe and debriding[7] the heel.

17. A CT angiogram[8] on 9 Month1 showed that there was severely restricted blood flow in Mr A's right foot, and it was recommended that in addition to the big toe amputation and heel debriding, Mr A be transferred to Waikato Hospital for surgery[9] to improve his circulation.

18. Between 9 and 12 Month1, clinicians discussed treatment options for Mr A with his family. The potential benefits of the surgery were explained, but the family was hesitant. Mr A's wife was recorded as being *"hesitant about surgery*", and there was some concern about how he would cope with a transfer to Waikato Hospital given his lack of comprehension of the situation. It was considered reasonable to wait for a couple of days because the wounds were chronic and, at that point, had not changed over Mr A's stay.

19. Following further discussion between clinicians and Mr A's family, on 12 Month1 a decision was made to transfer Mr A to Waikato Hospital for the recommended surgery.

Transfer to Waikato Hospital

20. Mr A was transferred to Waikato Hospital on 15 Month1. Vascular registrars assessed him and determined that he would most likely need a below-knee amputation. It is documented that Mr A's daughter believed "he would die; if [he had] amputation of [his] leg", and she preferred to do nothing. The registrars agreed that the risk of death from surgery was high.

21. On 16 Month1, Mr A's daughter discussed the surgical options with the clinician responsible for Mr A's care at Waikato Hospital, who explained that above-knee amputation would be preferable to below-knee amputation, as the former typically has better healing. The

[5] Sepsis secondary to lower respiratory tract infection and urosepsis.
[6] Bacteria.
[7] The medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue.
[8] A scan of the blood vessels.
[9] Angioplasty — a procedure to widen and open blood vessels to let blood through more easily.

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clinician also explained the low chance of healing fully from the amputation, and suggested that instead they could trial angioplasty,[10] which could improve blood supply and healing.

22. The clinician told HDC that he felt that the amputation had a fairly high chance of resulting in Mr A's death, whereas the angioplasty could save the limb, but had a fairly low chance of healing. However, if the angioplasty was unsuccessful, an amputation could still be performed.

23. An angioplasty was attempted on 16 Month1 but was abandoned as Mr A could not remain still.

24. On 23 Month1, an angioplasty was performed under general anaesthetic on two out of the three intended blood vessels.[11] The big toe was also amputated, and the heel was debrided.

25. Mr A was monitored at Waikato Hospital for two days, and on 25 Month1 he was discharged back to Gisborne Hospital. In its response to the provisional opinion, the family told HDC that it had the utmost respect for the care Mr A received at Waikato Hospital.

Second admission to Gisborne Hospital

26. From around 26 Month1, it was noted that there was a patch of dry gangrene[12] on Mr A's heel. The treatment plan at that point was to monitor it carefully.

27. By 15 Month2, Mr A's heel had not improved sufficiently for him to be discharged home. The dry gangrene remained largely unchanged. Long-term care options were discussed with the family.

28. On 16 Month2, it was decided that Mr A's heel might be improved by surgically removing the dead tissue.[13] This was performed on the ward. On 20 Month2, the remaining dead tissue came off. Again, long-term care options were discussed with the family.

29. By 27 Month2, it was noted that there was still no apparent healing. This was discussed with Mr A's daughter and a decision was made to amputate Mr A's leg. An above-knee amputation was carried out on 28 Month2.

30. On 31 Month2, a drain was removed from the wound at the amputation site, and it was noted that a large quantity of blood spurted from the area, travelling several feet over the end of the bed. Mr A was taken to theatre, and the wound was reopened. A clot was removed, and it was noted that there was no arterial bleeding.

31. On 4 Month3, the drains were removed again. On 6 Month3, it was noted that the stump was healing well.

[10] See footnote 8.

[11] The peroneal artery was completely blocked and therefore could not be operated on.

[12] Dry, shrivelled dead tissue caused when the blood supply to the area is cut off.

[13] Debridement.

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32. On 10 Month3, Mr A was discharged to a care home.

Issues raised by Mr A's family

33. Mr A's family raised numerous concerns, which are described below.

Coordination of care between Tairāwhiti and Waikato[14]

34. Mr A was transferred to Waikato Hospital on 15 Month1. The family said that they were told that his operation would be carried out on 16 Month1. However, Mr A was not operated on until 23 Month1. Ms B told HDC that this delay caused problems for the family because family members had arranged to travel to Waikato Hospital to support Mr A.

35. On 25 Month1, Mr A was transferred back to Gisborne Hospital. Ms B's complaint notes that on the morning of 26 Month1, a nurse asked a member of the family how to dress Mr A's wound at the site of the toe amputation. Ms B questioned why this issue was not covered by readily available handover notes from Waikato Hospital.

36. In response to the concerns raised by the family, Te Whatu Ora prepared a draft report (the Te Whatu Ora Report) on the care of Mr A. The Te Whatu Ora Report addressed the issue of continuity of care between Tairāwhiti and Waikato. Te Whatu Ora said that the patient's nursing records travel with the patient when they are returned to Tairāwhiti care, which serves as a tool to ensure appropriate follow-up care. Te Whatu Ora accepted that this does not replace the need for ongoing assessment and local updating of care plans.

37. Te Whatu Ora told HDC that Tairāwhiti and Waikato also share electronic records, and that there is well-managed transfer between the districts when a patient is handed over.

38. Mr A's Waikato patient notes and other records were included in the clinical records provided to HDC by Te Whatu Ora.

Coordination between teams within Tairāwhiti

39. Mr A's family raised a number of concerns about Te Whatu Ora's communication between the clinical and nursing teams, within the nursing teams, and with the family. They noted a "lack of cohesion and collaboration with all stakeholders on [the] ward". They also felt that different messages were being given to the family by different health professionals, and that at times there were contradictions between healthcare professionals.

40. The family said that one instance occurred on 31 Month1, when a family member noticed that Mr A had a new wound on the back of his head. When a nurse was questioned about it, she was not aware of the wound and suggested to them he must have fallen out of bed. It was only when a doctor overheard the conversation that a CT scan was ordered. It appears that the wound had been there since the previous day, and that nurses on the previous shift had been aware of it and had noted it in Mr A's patient notes. The patient notes on 1 Month2 record a lump on the back of Mr A's head as an "unwitnessed trauma". However, there is

[14] At the time of events, before the Pae Ora (Healthy Futures) Act 2022 came into force, Tairāwhiti and Waikato were separate legal entities.

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no further reference to the head injury in the patient notes. The family told HDC that Mr A could not have fallen out of bed, as he would not have been able to get back in again.

41. The Te Whatu Ora Report noted that an assumption was made that Mr A had fallen back while sitting, as he was known to be unstable while sitting, and given his lack of mobility, he could not have fallen out of bed and managed to get back in again. Te Whatu Ora considers that the normal observation levels already in place were sufficient for monitoring Mr A's condition, and that no further action was indicated. Te Whatu Ora noted that a CT scan was undertaken when the wound was discovered, but the result of the scan does not appear in the patient notes.

42. The family noted a second example concerning Mr A's discharge arrangements. The family said that they had been informed before his discharge that he would spend some time in a rehabilitation ward before being discharged. It was only on 9 Month3, on the evening before his discharge, that the family were told that he would be discharged directly to the care home.[15] The family also stated that they were informed by the care home that a charge nurse had tried to transport Mr A there the previous day — of which the family had no prior knowledge. The family felt that the charge nurse was dismissive when the lack of communication was raised with her.

43. The family also complained that before Mr A's discharge, no information was given to them about his ongoing rehabilitation or care, and consequently Mr A's wife was very anxious about the proper care of his wounds and her husband's dignity.

44. The Te Whatu Ora Report responded to the family's concerns about coordination between staff and teams. The Report noted that the wards undertake multi-disciplinary meetings twice per week, which are the forums for assuring that members of the team are up to date with recent assessments, plans, and expected outcomes. Te Whatu Ora told HDC that the daily ward rounds are also multi-disciplinary.

45. Te Whatu Ora also said that the patient notes record regular contact with the social work team, which was the lead team for Mr A's discharge planning, and the notes reflect regular meetings with Mr A and his wife. Te Whatu Ora stated that continuity is supported at Te Whatu Ora, and a transdisciplinary approach is used to reduce replication of effort.

46. However, Te Whatu Ora accepted that the focus on teams is an area that needs attention.

47. In relation to discharge planning, Te Whatu Ora told HDC that Mr A's clinical journey was long and complex, and that the multi-disciplinary team worked closely with Mr A and his family throughout, with ongoing assessment of Mr A's discharge destination. Mrs A believed that her husband would not be able to return home unless he could mobilise independently, but other family members were keen to explore higher levels of home care. Ultimately, it was not until it had been confirmed that Mr A needed an above-knee amputation that it was decided that he would be discharged directly to a care home.

[15] A residential aged care facility in Gisborne.

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Wound care

48. Mr A's family attribute the deterioration in the condition of his wounds to inadequate care by the nursing and clinical staff at Te Whatu Ora. Following his return from Waikato Hospital, the advice of the clinicians at Waikato was to change Mr A's wound dressings daily. Ms B's complaint notes that on 28 Month1, Mr A's new dressings remained outside his door until 4pm, when nurses on the evening shift carried out the change of dressings.

49. On the morning of 28 Month1, when doctors visited Mr A on their ward rounds, they commented that his wounds were healing well. Ms B believes that they could not have known whether the wounds were healing well, as they did not view the wounds on that day and, in fact, the wounds had already become weepy by that point.

50. On 30 Month1, Mr A's wounds were left undressed for several hours.

51. On 31 Month1, Mr A was lifted out of bed and into a wheelchair. His wounds were uncovered at this time and his heel was resting directly on the floor. As his weeping wound was sticking to the floor, a family member advised that he should place his feet on the footrests of the wheelchair. When he did so, a protruding part of the footrest went into his wound, causing him severe pain.

52. Ms B told HDC that it was from this point on that Mr A's wound deteriorated and the infection worsened. She said that the smell from Mr A's wound was so bad that some family members could not be in the room. When this was raised with a nurse, the nurse replied that the dressing was to be changed every five to seven days, when in fact that advice applied only to the toe wound covered by the negative pressure dressing, and not to the heel wound, which was to be changed daily. Mr A's family believe that had the care of his heel wound been adequate, the amputation of his leg could have been avoided.

53. Te Whatu Ora told HDC that it has a comprehensive wound management record that is completed at each wound change. Te Whatu Ora said that the patient records show that these were completed regularly with wound changes, and, in addition, the patient notes contain information regarding the wounds, including regular assessment by the wound clinical nurse specialist who had been directly involved in Mr A's wound management prior to his admission.

54. The patient record contains notes of dressing changes and observations of Mr A's wounds at various points. There are also detailed wound assessment and treatment records, and care plans, although these do not cover the entirety of Mr A's two stays at Gisborne Hospital.

55. Te Whatu Ora also provided copies of its guidelines on frequency of dressing changes, and a pro forma wound treatment plan and evaluation form.

Management of incontinence

56. Mr A required regular changing of his incontinence pad and the application of a barrier cream to prevent rashes, infections, and discomfort. His family complained that staff at Te Whatu Ora did not change Mr A frequently enough, and that sometimes a family member had to ask for him to be changed.

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57. The family told HDC that on many occasions Mr A was not changed out of nappies that had been soiled overnight until 10–10.30am. They said that because of this, Mr A developed severe rashes and excoriation of the skin on his groin to the extent that a course of antibiotics was required, and this caused Mr A pain and discomfort.

58. On 1 Month2, the urine tap on Mr A's catheter bag was left on overnight. It leaked into Mr A's bed, and this was not noticed for most of the night until the man in the neighbouring bed noticed and alerted nursing staff.

59. Te Whatu Ora told HDC that Mr A suffered from scrotal redness and excoriation before he was admitted, and that these were not new problems, although the family said that this condition had deteriorated considerably while he was in Gisborne Hospital.

60. Te Whatu Ora said that Mr A's incontinence-related skin problems were managed carefully, including the use of barrier creams, hygiene measures, and uridomes.[16] Eventually, following worsening of these conditions and a fungal infection, the matter was escalated, and a catheter was inserted to provide relief and protection and to allow Mr A's skin to recover. Te Whatu Ora said that ongoing assessment was carried out frequently, and when conditions worsened this was recognised early and managed promptly.

61. The patient notes contain regular references to incontinence pad changes and the skin problems Mr A suffered in his groin area. For example, on 15 Month1, the patient notes record that Mr A's groin was excoriated. The family told HDC that although Mr A was changed, the changes were not regular enough and often it was 15 or 16 hours between changes.

62. From early Month2, there are some records of attempts to explore other urinary incontinence solutions — for example, on 12 Month2 a nursing note records that the Uri-tip[17] Mr A was fitted with kept falling off, and that a catheter might be needed.

63. There are also some records of discussion about treatment for Mr A's skin issues. For example, on 2 Month2 it is recorded that Mr A saw the continence team, who recorded: "Supplied with secura cleanser, and dimethicone cream. Please use at each incontinent episode. Avoid washing excoriated areas with soap and water."

Pain management

64. Mr A was taking regular pain medication to manage the pain he was experiencing from his wounds. The family told HDC that although the pain medication was supposed to be administered every four hours, on 26 Month1 Mr A appeared to be in some discomfort, and a family member went to find a nurse to ask whether he had been administered his medication. The family told HDC that the nurse responded: "How should I know, I'm not his nurse." The family said that when asked if she could find out if Mr A had been administered his medication, the nurse replied: "Well if he was in any discomfort, he should just ask." The

[16] An externally worn device designed to collect urine.

[17] A brand of uridome.

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family feel that this was unacceptable and inappropriate, especially as Mr A was suffering from dementia and was hard of hearing.

65. Te Whatu Ora told HDC that Mr A's pain was managed appropriately, with regular base pain medication and stronger medication available if required. Te Whatu Ora said that the patient notes record many periods in which Mr A had no problems with pain. However, Te Whatu Ora accepted that the recording of a pain score would have been a more objective measure of Mr A's pain levels.

General

66. In relation to nursing tasks carried out to manage incontinence, pain, and wound dressing, the Te Whatu Ora Report commented on the way these cares are managed by nursing staff on the wards. Te Whatu Ora said that nursing and healthcare assistant allocation reflects the needs of the patients and the support they require. Cares are planned throughout the shift, taking into consideration urgency and priority of the tasks. When the demand is greater than capacity, the staff may ration care and allocate it either for later in the duty, or to be handed over to the following shift. Te Whatu Ora accepted that in Mr A's case, neither their own nor the family's expectations were met.

67. The Te Whatu Ora Report commented generally on nursing standards on the wards. Te Whatu Ora noted that standards benefit from leadership and clarity around expectations, and from staff feeling heard and invested in to be able to provide the care they want to provide. Te Whatu Ora said that the Director of Nursing position is key to setting the standards, and she takes this responsibility seriously.

68. Te Whatu Ora also said that at a department level, the charge nurse is accountable for ensuring that the standards are met, and the standards are measured against key performance indicators, which include monitoring standards and putting into place improvement actions.

69. The charge nurses highlighted that at times, they need to prioritise where their focus is in working with their team to ensure that care needs are met for each person on the ward. When the wards are under demand, by necessity the charge nurses take on a clinical role or have their time consumed finding staff to cover the roster. To maintain oversight of the care provided, they are present during ward rounds and are the conduit between the various professionals who are involved in the provision of care. They are also present during handover between shifts, and so understand what the pressures are.

Hygiene, including standards of dress

70. The family told HDC that conditions on Mr A's wards at Gisborne Hospital were not hygienic. They said that when their father was first admitted, the room he was in was full of stored equipment and supplies unrelated to his care. They expressed concern that this demonstrated a low standard of cleanliness and patient care.

71. The family also told HDC that staff on the wards did not adhere to appropriate standards of dress, uniforms were often mismatched, and that they observed ward staff wearing uniforms in the supermarket and then subsequently on the ward.

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72. They also commented that the general state of order and cleanliness was not good, including staff tracking dirt from outside through the hospital on their shoes.

73. The family submitted photographs to HDC showing clutter in Mr A's room, examples of non-standard uniform worn by staff, and some untidy cupboards left open on the ward.

74. The Te Whatu Ora Report outlined that ward cleanliness is monitored through infection control processes, which include environmental audits and monitoring of infection rates. Te Whatu Ora views those processes as adequate but noted that the Te Whatu Ora "cleaning and ward teams have attended to [the] feedback".

75. Te Whatu Ora provided HDC with examples of its cleaning services duty list, cleaning task checklists, housekeeping inspection reports, hazard identification checklists, infection control audit tools, and environmental audit summaries. The inspection reports generally record a high level of compliance with cleaning standards, although the examples provided do not always correspond with the dates on which Mr A was in the wards. The infection control audit tools record that, generally, ward hygiene was of a good standard. Again, the examples provided did not always correspond with the dates of Mr A's admission. Te Whatu Ora told HDC that this is because once the report is completed, the audit forms are not retained; however, some of the wards had a copy of the completed audit form, and these were provided to HDC.

76. Te Whatu Ora also told HDC that the photographs taken by the family are not representative. Te Whatu Ora said that the room used for Mr A's initial admission was only for an initial assessment of his confusion and dementia and mobility risk. The ward treatment room is located near to the nurses' station and provides an opportunity for close observation to inform ongoing assessment. Te Whatu Ora said that the treatment room has a set of shelves with commonly used treatment equipment, and a mobility aid and a transfer belt, which were needed for Mr A. Te Whatu Ora does not believe that this constitutes clutter or untidy areas. The family told HDC in response to the provisional opinion that Mr A was in the initial room for approximately five days, and not for initial admission only. They also said they were told that he was placed in that room due to a lack of beds.

77. In relation to the staff uniforms, Te Whatu Ora said that at the time of Mr A's admission, they were in the process of replacing uniforms, and the old uniforms were no longer available.

78. Te Whatu Ora also provided HDC with copies of its Dress Code Policy, both the version in effect at the time of Mr A's stay in Gisborne Hospital, and a revised version. I note that both versions require nursing staff to wear approved uniform, and to appear neat and clean at all times.

Condition and availability of equipment

79. The family expressed concern about the lack of availability of necessary equipment on the wards, and also about the condition of some equipment that was used.

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80. Mr A had wounds on his heel and his big toe. His family said that sometimes his wounds would catch on the bed end, and so they asked a number of times for the bed end to be removed and left off, or for an extension to be attached, as it had been at Waikato Hospital. They said that on two occasions during Mr A's first admission to Gisborne Hospital and on more occasions during his second, the bed end was reattached to the bed, causing problems with the healing of Mr A's foot wounds.

81. The Te Whatu Ora Report noted that its beds were not designed to have extensions attached, and the only alternative was to remove the end of the bed entirely, which was done on the request of the family.

82. The family also told HDC that on numerous occasions they asked for a pressure support for Mr A's foot because the ones he had obtained at Waikato Hospital kept coming off and getting tangled, because Mr A would move around a lot in his bed. They expressed concern that the same supports were being reused daily despite being contaminated by weeping from Mr A's wounds.

83. On 30 Month1, during ward rounds, doctors removed Mr A's wound dressings to view the progress of healing. A vacuum machine was required to dress the wounds again,[18] and the family said that it took two and a half hours for staff to locate one. During this time, Mr A's wounds were left uncovered. The family told HDC that Mr A's feet were cold, and they had to manage his positioning carefully to ensure that the wounds were not knocked. They believe that a vacuum machine should have been available sooner.

84. The Te Whatu Ora Report noted that vacuum machines are tracked and held centrally, as they are used both in the community and in the wards. Delays can occur because the machines are used across the whole organisation, and therefore it may be necessary to wait for equipment to become available.

85. The family also told HDC that the wheeled food trays Mr A was provided with were damaged and not fit for purpose. They said that initially, Mr A was given a wobbly tray, which was not suitable for a man of his years with limited mobility. They stated that the replacement tray was also damaged, in that it had splits in it.

86. The Te Whatu Ora Report addressed the issue of the condition and availability of equipment. Te Whatu Ora noted that within the organisation there is a gap between need and affordability, which results in rationing of some articles. A full replacement programme for some items, including over-the-bed tables, was undertaken in 2018 for some wards, but there is a need to review some items further. Te Whatu Ora agreed that there is also a need for clinical input into purchasing decisions to ensure the alignment of clinical need and cost.

87. Te Whatu Ora provided HDC with copies of its health and safety audits and hazard identification checklists for the period of Mr A's admission at Gisborne Hospital. The audit summaries completed in June 2019 and January 2020 identify cracked bedside tables as an

[18] Mr A's wounds were treated with negative pressure wound therapy — a special dressing is sealed over the wound and a vacuum pump is attached to draw out fluids.

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issue, although the January 2020 summary also records that audit documents were not supplied for two wards. The issue of damaged tables is repeated in the September/October hazard identification checklist (in addition to two bedside lamps in need of repair). Although there are spaces on the hazard identification checklists to record what actions need to be taken, by whom, by when, and a space for marking the action as complete, generally (ie, with some exceptions) these portions of the forms have not been filled out.

Weighing of Mr A

88. A nursing note dated 6 Month1 (the date of Mr A's admission) states that Mr A was unable to be weighed because he was not mobilising. Te Whatu Ora told HDC that it is not uncommon for patients not to be weighed if they are not mobilising, and that some assessments are delayed if they are not significant to the treatment plan at that time. Te Whatu Ora said that both seated and wheelchair scales were available, but these were located at a distance from the ward, and so were not used at that particular time.

89. On the Te Whatu Ora pre-flight assessment form, dated 15 Month1, Mr A's weight is recorded as 92kg. A note from a student dietitian dated 22 Month2 records a recent 5kg weight loss, estimated by Mr A's wife. The dietitian's note requests that Mr A be weighed, as does a similar dietitian's note dated 4 Month3.

Expectations of privacy

90. On the wards, patient notes are kept by the nurses' station. Photographs provided by the family show that patient notes were left where they could be seen by people in public areas. The family told HDC that this raised concerns about patient privacy, and they feel that patient notes should be kept at the ends of patients' beds.

91. Te Whatu Ora told HDC that in the past it had kept notes at the end of the bed but found that this also presented its own privacy issues.

92. The family also told HDC that they overheard conversations between staff about other patients, some of whom were known personally.

93. The Te Whatu Ora Report noted that privacy is a specific difficulty in its open four-bed rooms, where the large majority of people are cared for. Te Whatu Ora said that staff are reminded of the need to seek privacy for more sensitive information to be shared, but it is unable to eliminate the possibility that conversations at the bedside will be overheard, and it recognised that this can be uncomfortable.

Assistance with mealtimes and nutrition

94. Following Mr A's surgery at Waikato Hospital and his return to Gisborne Hospital, it was recommended by clinicians that he sit up on the edge of his bed to take his meals. This was intended to get him up and moving and to give him tasks to aid his recovery. At each mealtime, a member of the family was present to help Mr A to eat and drink properly. The family told HDC that staff members on the wards usually took breaks at the same time that patient meals were served. The family feel that staff breaks should be structured to allow for helping patients who need assistance with eating.

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95. The family told HDC that on the morning of 28 Month1, a family member rang Mr A's buzzer to request help to get him into an upright position to eat his breakfast. They said that when a nurse arrived, she said: "I haven't got time for that, you will have to do it yourself." The family believe that the nurse could have easily helped in the time it took her to come to the bedside. They said that the nurse then went back behind the nurses' station and sat down.

96. The family stated that on 30 Month1 they again asked for assistance to get Mr A to sit on the side of his bed to eat his breakfast. They said that at this time, the nursing staff only propped up Mr A in bed, rather than helping him to sit on the side of the bed as instructed.

97. The family also told HDC that Mr A's food intake was not monitored properly during his stay, and that given his diabetes, this could have been dangerous for him. Their complaint noted that the family witnessed other patients' food remaining uneaten because the patients were not able to feed themselves, and that no help was offered by hospital staff at these times.

98. The Te Whatu Ora Report said that usually meal breaks are arranged in two blocks so that there is ward cover at all mealtimes. If patients require meal support, they are either prepared in advance of the meal arriving or, if necessary, the meal is held until staff are available to assist. Te Whatu Ora expressed disappointment that Mr A's family felt the need to be present at all times during meals, and that they had the impression that staff were taking liberties with meal breaks.

99. Te Whatu Ora also told HDC that Mr A's nutritional needs were being monitored closely, and that the patient notes show that there was nursing input into Mr A's mealtimes and his nutritional support. For example, an entry on 2 Month2 records, "Pt transferred to chair using […] — steady for dinner"; on 3 Month2, "Didn't eat much tonight, assisted by wife. Requested Fortisip, drank half"; and on 5 Month2, "Full diet tolerated with prompting of wife … Pt up for dinner in chair with assist x2."

100. Te Whatu Ora also said that twice-weekly multidisciplinary "at the board" meetings occur, in which all patients are discussed (including their nutrition) with the wider allied,[19] medical, and nursing teams to ensure timely referrals and responses.

101. Te Whatu Ora provided HDC with care plans in the clinical records that include sections on nutrition and hydration. The instruction on the pro forma plan is to "describe how nutritional and hydration needs are met. Complete MST[20] score weekly …" However, there is little detail in the various fields about Mr A's nutrition plan, and the large majority of entries read only "DAT[21]" and/or "Diabetic diet".

Further information

102. On 1 Month4, the family made a complaint by email to various parties, including HDC. Following that, Te Whatu Ora conducted an investigation that resulted in the Te Whatu Ora

[19] Allied health professionals are health professionals who are not part of the medical, dental or nursing professions, eg, physiotherapists.

[20] Malnutrition screening tool — a measure of the risk of a person becoming malnourished.

[21] Diet as tolerated.

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Report. Te Whatu Ora initially told HDC that the Te Whatu Ora Report was a draft, but in a later email, Te Whatu Ora stated that the Report constituted the result of Te Whatu Ora's investigation into the complaint.

103. On 30 January 2020, various Te Whatu Ora staff members and the family met. The family had received a copy of the Te Whatu Ora Report and had requested a meeting because they were unhappy with it. The family felt that the report was filled with rhetoric and excuses and did not provide any solutions to the problems they identified with the nursing care Mr A had received.

104. A second meeting between Te Whatu Ora and the family was held on 10 March 2020. That meeting ended with little resolution, but generally the family stressed that they wanted details on how Te Whatu Ora monitors and enforces nursing competencies and standards, answers to a list of questions put to Te Whatu Ora, and to see a change in nursing culture at Te Whatu Ora.

Responses to provisional opinion

105. The family and Te Whatu Ora were given the opportunity to respond to the provisional opinion. Te Whatu Ora did not respond. The family's responses are incorporated into this report where appropriate. In addition, they told HDC:

> "Te Whata Ora have never apologised for their actions nor have they provided any positive solutions to satisfy the substandard health care other than recite processes and policies already in place, rather than look at what are the steps and consequences when these fall down.
>
> Thank you for allowing us to review this report and provide feedback. We have [not] had nor can we see any real evidence or reassurance that standards have been raised in the areas we have alluded to. It is unfortunate as this does not raise our confidence or raise the confidence within our community about receiving an expected level of care as in other parts of NZ."

Opinion: Te Whatu Ora Tairāwhiti — breach

Failure to provide services with reasonable care and skill

Coordination between teams within Hauora Tairāwhiti

106. The family lists a number of examples that they say demonstrate a lack of coordination between teams and individuals at Te Whatu Ora.

107. Te Whatu Ora responded that there was substantial coordination within Te Whatu Ora, and that the regular multi-disciplinary team meetings and weekly multi-disciplinary ward rounds demonstrate this. Te Whatu Ora also said that the patient notes show good co-ordination with the social work team regarding Mr A's discharge planning, and regular meetings with the family.

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108. Te Whatu Ora noted that Mr A's clinical journey was long and complex, and therefore it was difficult to plan for discharge until the outcome of the journey was known.

109. I obtained independent advice from a nurse practitioner, Stephanie Thomson, to assist me in this investigation. Ms Thomson considers that there is little evidence of coordination or collaboration between the multi-disciplinary team members and the family. I agree. Although there are some scattered references to discussions with the family, I cannot see any evidence of a sustained multi-disciplinary approach such as the approach Te Whatu Ora advised HDC was in place. Had such an approach been in place, I would expect to see notes of multi-disciplinary team meetings and input from the family.

110. It may be that there was a failure in documentation at Te Whatu Ora rather than in a multi-disciplinary approach, but I am guided by the evidence before me. Ms Thomson advises me that this was a severe departure from the standard of care. I accept that there are inadequacies in the coordination of care, but there are references in the clinical notes to the teams coordinating with each other and there were regular multi-disciplinary team meetings and multi-disciplinary ward rounds. Although I agree with Ms Thomson that it was a departure from the standard of care, I acknowledge that Mr A had a very long and complex care journey, and I find that this was a moderate departure from the standard of care.

111. I do accept that discharge planning was difficult given Mr A's complex clinical journey, and I am not critical of the lateness of the decision to discharge Mr A to the care home. However, it appears that communication of the decision with the family could have been better. I will address the issue of communication with the family in my comments about the general multi-disciplinary approach.

Head wound

112. The family cite the head trauma suffered by Mr A while on the ward at Gisborne Hospital as an example of a failure of coordination between teams. With no further mention in the notes of the head trauma following the note on 1 Month2, it is difficult to determine what, if any, follow-up was undertaken.

113. Te Whatu Ora told HDC that the observation levels already in place when Mr A hit his head were sufficient, and there was no indication for increased levels of observation.

114. Ms Thomson noted the failure to carry out further follow-up, such as neurological checks, investigation into how the lump occurred, medical follow-up of the CT scan, or communication with the family, and said that the patient notes contain no recording of the head CT scan. Ms Thomson advised that these omissions constitute a serious departure from the standard of care.

115. I accept Ms Thomson's advice. Te Whatu Ora nursing staff simply assumed that Mr A had hit his head when he had fallen backwards in bed and took no further action. Te Whatu Ora said that a CT scan was undertaken, but there is no record of the results. In my view, it is standard practice to follow up the results of a CT where one is carried out. Given that the trauma was not witnessed, I also would have expected extra measures to have been put in place to ensure that the trauma had not resulted in serious injury to Mr A, and to ensure his

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ongoing safety. As Ms Thomson suggests, this could have included a neurological assessment. I accept that the measures already in place included intentional rounding, which would have helped to monitor Mr A to some extent. Nevertheless, the measures in place were inadequate in the circumstances.

Wound care

116. The family reported that the nursing care of Mr A's wounds while on the wards at Gisborne Hospital was inadequate. They also told HDC that bed extensions Mr A needed to protect his wounds from bumping on the end of the bed were not available, and that pressure supports and a vacuum machine were not available when needed.

117. Te Whatu Ora told HDC that wound changes were completed regularly, and a comprehensive wound management record was completed at each change. In addition, a wound clinical nurse specialist reviewed Mr A's wounds regularly. The patient records do contain a number of wound care records, including completed wound assessment and treatment forms, and wound care plans.

118. It is difficult to determine whether Mr A's wounds were being managed appropriately. There is anecdotal evidence from the family that Te Whatu Ora nursing staff were unaware of the appropriate wound care regimen for Mr A. However, there are records of wound monitoring, plans for care, and documentation of wound care during Mr A's inpatient stay.

119. Ms Thomson advised that the Te Whatu Ora wound documentation was very difficult to read or track the status of the wounds, and that the records were incomplete. She said that she would like to see the Te Whatu Ora wound documentation reviewed, streamlined, and made more user friendly.

120. In comparing the dates of the Te Whatu Ora wound treatment and monitoring records with the dates of Mr A's stay in Gisborne Hospital, it is clear that there are gaps. Whether these gaps are the result of documentation not being completed, or a lack of wound care and monitoring is not clear.

121. In addition to the complaints about wound management, and the lack of documentation, I also note the problem with finding a vacuum machine to dress Mr A's wound, and the problem with the bed end that Mr A repeatedly bumped his heel wound against.

122. I find that cumulatively there is sufficient evidence that Mr A's wounds were not being managed appropriately during his inpatient stay at Gisborne Hospital. HDC requested all of Mr A's wound care records from Te Whatu Ora, and therefore I must conclude that if all relevant dates are not covered, either the wound care was inadequate during the missing dates, or important documentation was not completed. I also note Ms Thomson's advice that the wound documentation provided to HDC is hard to follow.

Management of incontinence

123. The family told HDC that Mr A's incontinence was not managed properly on the wards at Gisborne Hospital. They said that his incontinence pad was not changed often enough, and that rashes and sores on his groin developed as a result of this.

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124. Te Whatu Ora said that Mr A suffered scrotal redness and excoriation before he was admitted, and that these were not new problems. Te Whatu Ora considers that Mr A's incontinence-related skin problems were managed carefully and escalated when appropriate.

125. Ms Thomson advised that despite notes showing that Mr A's incontinence pad was changed at least once or twice per shift, serious concerns remain. Although barrier cream was applied to Mr A's groin regularly, by 15 Month1 his skin was described as being excoriated. Alternative methods to maintain his skin integrity should have been tried earlier. There was also no discussion recorded between the nursing team and the medical team about assessment and interventions to manage Mr A's incontinence and skin integrity. In addition, there were no planned toileting attempts, which may have prevented faecal incontinence, or timely discussion around catheterisation. In light of Mr A's history of groin thrush and the antibiotics he was taking, it would have been helpful to start the antifungal cream earlier. There was also no note of nursing escalation of concern despite multiple nursing notes that Mr A's groin was getting worse. Given the issues, a continence nurse referral should have been made earlier than 2 Month2.

126. Ms Thomson regards these failures as a serious departure from the standard of care, and I accept that advice. There are multiple handwritten patient notes recording the worsening of Mr A's groin skin issues, but that monitoring does not seem to have resulted in the care Mr A needed, and in particular it did not result in timely interventions to prevent the worsening of Mr A's skin integrity. The interventions appear to have been largely reactive rather than proactive.

Assistance with mealtimes and nutrition

127. The family told HDC that they did not think the assistance offered by nursing staff to help Mr A with his meals was sufficient, and that staff meal breaks were unhelpfully taken at the same time as patient mealtimes. They also observed that Mr A's nutrition was not monitored properly and said that this was dangerous for him as a diabetic.

128. Te Whatu Ora advised that staff meal breaks are taken in two blocks to ensure that staff are available at all times, and that if patients require meal support, they are provided with it. Te Whatu Ora also said that Mr A's nutritional needs were being monitored closely, and that the patient notes show this. Te Whatu Ora provided copies of care plans, including a section on nutrition and hydration, but these contain little information.

129. Ms Thomson advised that the expectation was that nursing staff would ensure that patients received the care and assistance they required with eating or drinking, and that special needs and restrictions were met. This includes making sure that the patient has appropriate nutrition and fluids.

130. Ms Thomson is critical of Te Whatu Ora's assistance with, and monitoring of, Mr A's nutrition. She noted that the dietitian's notes confirm that Mr A was not meeting daily caloric requirements and that he had had an estimated 5kg weight loss. Ms Thomson also noted that a patient with Mr A's medical needs should have had more oversight from the

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nursing team with his meals. Although that could include assistance from the family if that was agreed, there is no record of discussion or agreement on how and to what extent the family would be involved. There was also no documentation of admission weight, weight throughout Mr A's stay, or planned interventions to ensure that Mr A received assistance with his meals. Ms Thomson regards these issues as a severe departure from the standard of care.

131. I acknowledge Te Whatu Ora's comment that the dietitian's note that Mr A had lost 5kg was an estimate, and that his true weight, measured when he was being prepared for the flight to Waikato, was significantly higher. However, I accept Ms Thomson's advice that appropriate monitoring of nutrition includes taking appropriate steps to measure and record the amount, type, and regularity of food and fluid intake, and how that intake affects the health of the patient. Although there are some scattered references to weight and nutrition throughout the patient notes, these do not demonstrate the regular nutrition monitoring Mr A required. At a minimum, there should have been a proper nutrition plan, and the agreed involvement of the family, with regular reviews of the effectiveness of the plan. The purpose of the nutrition and hydration monitoring documentation is to assess how well the nutritional and hydration needs are being met. I am concerned that the nutrition and hydration monitoring documentation was not completed regularly or in detail.

132. As the student dietitian had requested, Mr A should have been weighed regularly. Ms Thomson advised that he should have been weighed at least weekly (and that requirement is recorded in the risk assessment completed by Te Whatu Ora on Mr A's admission to Gisborne Hospital). There is no documentation of weekly weighs, and Te Whatu Ora acknowledged that Mr A was not weighed on admission and noted that the 5kg weight loss recorded on 22 Month2 was an estimate by Mrs A. Te Whatu Ora told HDC that sling and wheelchair scales are available at a distance from the wards, but there is no evidence these were used. I find it more likely than not that Mr A was not weighed regularly, and I am critical of Te Whatu Ora in this respect.

133. Although I agree with Ms Thomson that the Te Whatu Ora failures in respect of Mr A's nutrition and nutrition monitoring constitute a departure from the standard of care, I find that this was a moderate departure. I accept that there were inadequacies, as mentioned above, but the references in the clinical notes to weight and nutrition suggest that Mr A's nutrition was monitored to some extent. I acknowledge that Mr A had a very long and complex care journey.

Condition and availability of equipment

134. The family listed a number of examples of equipment that was either not available when required, or defective. In particular, they noted that wheeled food trays were broken or cracked.

135. Te Whatu Ora responded that budget constraints led to rationing of some items.

136. Ms Thomson advised that use of defective food trays is a severe departure from the standard of care, particularly because cracked trays can have significant infection control consequences. She noted that the health and safety audits did identify the cracked tables

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(and other issues), but that there was no clear process for following up and resolving those issues.

137. Ms Thomson also advised that the Te Whatu Ora audits she reviewed shared a common theme that there was no "closed loop" — ie, although issues were identified, there was no clear process on how they would be actioned or who would action them.

138. I accept Ms Thomson's advice that defective food trays are a departure from the standard of care, but in the context of resourcing constraints, I find that it is a mild to moderate departure. There will be shortages of some equipment due to budget constraints, and I consider that it would be preferable for defective food trays and tables not to be used on the wards because of the increased risk of infection. I also note that Te Whatu Ora has advised HDC that purchasing of new over-the-bed tables is part of its capital replacement plan. In my recommendations below, I have asked Te Whatu Ora to confirm that new tables have been purchased.

139. I also accept Ms Thomson's advice that there does not seem to be a clear process for "closing the loop", and I am critical that the documents Te Whatu Ora provided do not show when and how the issues identified were resolved (if they were at all).

Conclusion

140. Overall, for the following reasons, I find that Te Whatu Ora|Health New Zealand breached Right 4(1)[22] of the Code of Health and Disability Services Consumers' Rights (the Code):

a) Mr A's wounds were not managed appropriately, or the management was documented inadequately.

b) The cause of Mr A's head wound was not investigated adequately, and appropriate measures were not put in place to monitor him following the incident.

c) Mr A's incontinence was not managed adequately, and the resulting skin problems were not treated in a timely and proactive manner.

d) There was a serious lack of oversight and monitoring of Mr A's nutrition, including assistance during mealtimes, and weighing of Mr A at appropriate intervals.

e) Cracked and defective food trays were provided to Mr A.

f) The multi-disciplinary approach to patient care was inadequate.

Adverse comments

Hygiene concerns and uniform standards

141. It is unclear from the evidence what the general state of hygiene and tidiness was in the wards. The family provided photographs which they say are examples of disorder and clutter in the room in which Mr A was first placed when he was admitted to Gisborne Hospital. They

[22] Right 4(1) of the Code requires healthcare providers to provide services with reasonable care and skill.

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also cited examples of staff wearing non-standard uniform and of tracking dirt into the ward on their shoes.

142. Te Whatu Ora responded that despite the possibility of some isolated incidents, hygiene standards on the wards are high, and appropriate control methods are in place to monitor hygiene. In relation to the uniforms, Te Whatu Ora acknowledged that there may have been inconsistencies in staff uniforms but said that this was a temporary issue that would be resolved by the ongoing purchase of new uniforms. Te Whatu Ora denied that there was any issue with clutter in Mr A's room and said that the items there were required for Mr A.

143. Ms Thomson reviewed the health and safety checklists, housekeeping audits, infection control audits, and environmental audits provided by Te Whatu Ora and advised that although not all were dated from the time Mr A was on the wards, those that were present appeared comprehensive. In relation to the clutter in the treatment room on the ward where Mr A was initially, Ms Thomson advised that considering the monthly housekeeping audits for 2019, it appears that overall, the housekeeping standards were maintained. Ms Thomson advised that if the treatment room was clean and tidy, as reflected in the audits, using the treatment room would be a suitable temporary bed assignment in a tight bed situation.

144. I accept Ms Thomson's advice. There is some evidence of untidiness shown in the photographs provided by the family and from their accounts of their experiences on the wards, but the processes Te Whatu Ora had in place to manage hygiene and the ward environment appear to have been acceptable. I accept that any incidents of untidiness or unhygienic situations are likely to have been isolated incidents and not representative of the usual standard at Gisborne Hospital.

145. Ms Thomson noted that a cluttered and untidy patient care environment is unacceptable. I accept that advice and remind Te Whatu Ora that standards of tidiness and cleanliness should be maintained at all times.

146. In relation to the uniforms, Ms Thomson advised that it is desirable to have a high standard of dress. She said that the family's descriptions of "a mismatch of uniforms" and Te Whatu Ora's plan for new uniforms across the hospital led her to believe that there was either a lack of uniform policy, or a lack of adherence to that policy. I agree and am concerned that the policy was not enforced appropriately. I note with approval Te Whatu Ora's comment that new uniforms are being purchased, and I remind Te Whatu Ora of the need to maintain appropriate uniform standards.

Pain management

147. The family raised concerns about whether Mr A's pain medications were being managed appropriately. They found it difficult to determine whether the medication had been administered as prescribed, and they found responses from nursing staff to be dismissive.

148. Te Whatu Ora told HDC that Mr A's pain medication was managed appropriately, and that there were long periods when he had no problem with pain. However, Te Whatu Ora

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accepted that the recording of a numerical pain score would have been a more objective measure of Mr A's pain.

149. Ms Thomson acknowledged that Te Whatu Ora was in a challenging situation regarding Mr A's pain management because he suffered poor kidney function and so could not take some analgesics, and opiates would be a problem because of his dementia and drowsiness. However, she agreed with the family that it was difficult to tell what pain medication he had been administered. Ms Thomson noted that the pain score recordings were either left blank, or marked only with a tick, and she is unsure what this meant.

150. From the available documentation, it is difficult to tell whether Mr A's analgesics were administered appropriately. I remain concerned about the unclear recording of analgesic administration and pain scores, and I note that the recording of a numerical pain score would have been more appropriate.

Other comments

Condition and availability of equipment

151. As noted above, the family told HDC that the bed extensions Mr A needed to protect his wounds from bumping on the end of the bed were not available. They also said that pressure supports and a vacuum machine were not available when needed.

152. Te Whatu Ora explained that its beds were simply not designed to have extensions attached. Ms Thomson agreed with Te Whatu Ora that removal of the foot of the bed was a sensible solution to avoid further injury to Mr A's foot where bed extensions were not available. Ms Thomson advised that using a pressure support such as a foam boot on a vulnerable area can increase shear and friction, so not using a foam boot could have been a reasonable nursing decision.

153. I accept Ms Thomson's advice. Although it would have been ideal to have had bed extensions available to help Mr A avoid bumping his heel wound on the end of the bed, it is difficult to be critical of Te Whatu Ora in this respect if the beds were simply not designed to accommodate extensions. In relation to the failure to provide a foam boot, I consider that this was a reasonable nursing decision and, accordingly, I find that Te Whatu Ora did not breach the Code in this respect.

154. In relation to the vacuum machine, Te Whatu Ora explained that the delay was caused because the machines are held centrally and may be in use or being cleaned. It is unclear whether a vacuum machine to dress Mr A's wound should have been available sooner, and I am unable to make a finding on this point. However, I have discussed Mr A's wound care more generally above.

Expectations of privacy

155. The family is concerned that often Mr A's patient notes were kept on a table at the nurses' station where they could be seen, and that they could hear private conversations between staff about other patients. They suggested that it would be preferable for patient notes to be kept at the end of patients' beds.

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156. Te Whatu Ora responded that staff are reminded of the need for privacy, but that they are unable to eliminate the possibility that conversations at the bedside will be overheard. They also said that keeping patient notes at the end of the bed also has privacy issues.

157. Ms Thomson said that healthcare providers are obliged to keep an individual's health information secure and must do everything reasonable to prevent unauthorised use or disclosure of an individual's health information.[23] She advised that keeping records at the end of the bed does not guarantee that patient records will remain secure.

158. I accept Te Whatu Ora's explanation that keeping patient notes at the end of the bed poses privacy issues and that staff are unable to eliminate the potential for bedside conversations to be overheard in a ward setting and open four-bedded rooms.

159. I consider that in this instance there has not been a breach of the Code, but I remind Te Whatu Ora of its obligations regarding the privacy of consumers' health information.

Coordination of care between Tairāwhiti and Waikato

160. The family feel that there is evidence that the coordination of care between Tairāwhiti and Waikato Districts[24] was not of an acceptable standard. They pointed to a delay in Mr A's surgery at Waikato and a comment by a nurse at Gisborne Hospital asking how Mr A's wound should be dressed.

161. Ms Thomson advised that there were appropriate and detailed handovers and assessments between Tairāwhiti and Waikato. I have reviewed the detailed notes, including comprehensive Tairāwhiti pre-flight assessments. I also note that the delay in Mr A's surgery at Waikato appears to have been caused by clinical factors, in particular the failed angioplasty attempted on 16 Month1. Accordingly, I find that Te Whatu Ora did not breach the Code in its coordination of Mr A's care between Tairāwhiti and Waikato.

Conclusion

162. Mr A spent a considerable amount of time on two wards between Month1 and Month3. He was an elderly man with complex health needs that required careful nursing management. The family are of the view that the standard of care was so low on the wards that it could have ended Mr A's life if they had not been present to advocate for him. Although it is impossible to determine whether these problems contributed to the deterioration in Mr A's condition, it is certainly a possibility.

[23] Rule 5 of the Health Information Privacy Code requires health agencies to ensure that health information is protected by such security safeguards as are reasonable in the circumstances to take, against loss, access, use, modification, or disclosure that is not authorised by the agency, and other misuse. See: https://www.privacy.org.nz/assets/New-order/Privacy-Act-2020/Codes-of-practice/Health-information-privacy-code-2020/Health-Information-Privacy-Code-2020-website-version.pdf. Accessed 13 December 2022.

[24] The original complaint was in respect of the former Tairāwhiti DHB and Waikato Hospital. As noted earlier in this report, district health boards were disestablished by the Pae Ora (Healthy Futures) Act 2022.

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163. Mr A was particularly vulnerable to infections. I consider that the use of damaged equipment that could harbour bacteria was unacceptable. I also consider that Mr A's wound care was not of an appropriate standard.

164. Other failures included inadequate monitoring of Mr A's nutritional intake and weight; a lack of proactive treatment of his deteriorating skin integrity; a lack of investigation and monitoring of his head wound; and a lack of documentation to show the multi-disciplinary approach described by Te Whatu Ora.

165. The family made a number of comments relating to the standard of nursing care generally, many of which relate to cares being carried out infrequently or improperly (eg, the frequency of wound dressing, or incontinence management). Te Whatu Ora told HDC that nursing allocation reflects the needs of the patient, but that where there is a shortfall in nursing capacity, staff may ration care and allocate it either for later in the shift, or to be handed over to the following shift.

166. In hospital settings, often there will be a shortfall in capacity where there are insufficient staff or resources to carry out the tasks required. I accept that in those situations there will need to be some rationing of cares. However, during Mr A's two stays at Gisborne Hospital, the failures that occurred went beyond what is to be expected from the normal stresses and pressures caused by resourcing constraints. In my view, the number and scope of those failures points to serious systemic failures in nursing at Gisborne Hospital at the time.

Changes made

167. Since these events, Te Whatu Ora Tairāwhiti has made a number of improvements and changes in its processes and policies, as follows.

168. Te Whatu Ora Tairāwhiti's capital replacement plan included the purchase of new beds that are able to have extensions attached, and that also have built-in scales for weighing patients.

169. Staff uniforms have now been replaced with new ones across Te Whatu Ora Tairāwhiti, and Te Whatu Ora Tairāwhiti's dress code has been extended for nursing staff.

170. There is a dedicated bed management policy.

171. Te Whatu Ora Tairāwhiti has formed a consumer council to support the existing methods available for patients and whānau to provide feedback.

172. Te Whatu Ora Tairāwhiti is also working on nursing care standards, which it has undertaken to provide to HDC once completed.

173. Te Whatu Ora Tairāwhiti also told HDC that it is endeavouring to improve its culture by:

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a) Actively engaging in the Speaking Up for Safety Programme by the Cognitive Institute; and

b) Implementing the Health Quality & Safety Commission's Kōrero Mai programme (piloted on one of the wards on which Mr A spent some time).

174. Te Whatu Ora Tairāwhiti also told HDC:

"The DHB has/is improving/reviewing many of the areas for example the DHB has completed FTE calculations for matching staffing resource to [patient] clinical needs using the nationally agreed tool, variance response plans and monitoring have been implemented … [T]he development and implementation of an acute pain service has been approved and is progressing, EWS are monitored and audited, nursing [job descriptions] have been reviewed across all levels of the profession."

Recommendations

175. I recommend that Te Whatu Ora Tairāwhiti:

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

b) Review its health and safety audits and tools, housekeeping audits and tools, and infection control audits and tools in light of Ms Thomson's criticism that there is no closed loop — ie, although issues are identified, there is no clear process on when, how, or who is to action them. If a similar review was carried out following the Ministry of Health's June 2019 Tairāwhiti DHB certification audit summary and the more recent February 2021 Surveillance Audit Report,[25] I recommend that Te Whatu Ora Tairāwhiti provide HDC with a detailed report on the outcome of that review as it relates to the issues noted in this paragraph. In either case, Te Whatu Ora Tairāwhiti should audit the regular use of those features of the tools designed to facilitate and monitor corrective action implementation for the two wards that Mr A was on, and report back to HDC with the results of the audit within six months of the date of this report.

c) Confirm the completion of its replacement programme for over-the-bed tables. Te Whatu Ora Tairāwhiti should conduct an audit of a representative sample of equipment used by patients on the wards (including over-the-bed tables) to assess the condition of equipment and report the results of the audit to HDC, within three months of the date of this report. If any findings show a shortfall in compliance, Te Whatu Ora Tairāwhiti is to include in its report to HDC any corrective actions taken to address the shortfalls.

[25] Both reports are available at https://www.health.govt.nz/new-zealand-health-system/monitoring-health-and-disability-services/tairawhiti-health-quality-and-safety. Accessed 5 September 2022. Both identified that corrective action implementation has been a recognised problem in the past, including in the areas of monitoring, documentation, and timely completion of corrective actions.

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d) Carry out an audit of the nutrition/hydration section of patient care plans for patients on the two wards using a random sample of 50 care plans from the 12 months preceding the date of this report to determine whether the plan and subsequent evaluations are being completed in full. Te Whatu Ora Tairāwhiti is to report to HDC on the results of this audit within six months of the date of this report. If any findings show a shortfall in compliance, Te Whatu Ora Tairāwhiti is to include in its report to HDC any corrective actions taken to address the shortfalls.

e) Carry out an audit of incidents in the ward using criteria from its guidelines/protocol on unexplained injuries on the wards. The audit should include whether these were reported via the incident management system, the investigations and follow-up care undertaken, and the documentation of the incidents. Te Whatu Ora Tairāwhiti is to report back to HDC with the results of the audit within six months of the date of this report. If any findings show a shortfall in compliance, Te Whatu Ora Tairāwhiti is to include this in its report to HDC, and any corrective actions taken to address the shortfalls.

f) In light of Te Whatu Ora Tairāwhiti's advice to HDC that it would be reviewing documentation of regular multi-disciplinary meetings, consider developing a tool to document and monitor multi-disciplinary team meetings, and report the results of its consideration to HDC within six months of the date of this report.

g) Review its wound management assessment and monitoring tools against international standards or confirm that it uses a wound management and assessment tool for its inpatient ward patients. The tool should incorporate the wound management suggestions made by Ms Thomson in her advice, including regular recording of objective measurements of wounds, a clear description of the wound, the cause of the wound, where the wound is located, instructions for types of dressings, and timing of dressing changes. Te Whatu Ora Tairāwhiti is to implement these changes (or confirm implementation of the changes) and audit compliance with the regular use of the tool by ward staff, and report to HDC on the implementation and audit within six months of the date of this report.

h) Report to HDC on the review of its pain management programme, within three months of the date of this report.

i) Carry out a baseline audit of continence assessments and corresponding care plans, which should include whether the assessed needs are being addressed appropriately by the interventions, and whether there is a clear evaluation plan (including frequency of review, referral, etc). Te Whatu Ora Tairāwhiti is to report back to HDC with the results of the audit within six months of the date of this report. If any findings show a shortfall in compliance, Te Whatu Ora Tairāwhiti is to include this in its report to HDC, and any corrective actions taken to address the shortfalls.

j) In light of Te Whatu Ora Tairāwhiti's advice to HDC that a review of the nursing documentation was scheduled for completion in 2022, report to HDC on the scope and progress of that review, within three months of the date of this report.

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176. Where any audit recommended above results in corrective action to address shortfalls, I recommend that Te Whatu Ora Tairāwhiti carry out a further audit three months from the implementation of the corrective action to assess the effectiveness of the corrective action. Te Whatu Ora Tairāwhiti is to report to HDC on the results of any further audits within six months of the implementation of the corrective action.

Follow-up actions

177. A copy of this report with details identifying the parties removed, except the advisor on this case, Te Whatu Ora Tairāwhiti, Gisborne Hospital, and Waikato Hospital, will be sent to the Nursing Council of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

178. As the Ministry of Health's June 2019 Audit Report on Tairāwhiti District Health Board — Gisborne Hospital and the more recent February 2021 Surveillance Audit Report identified that corrective action implementation has been a recognised problem in the past, including in the areas of monitoring, documentation, and timely completion of corrective actions, this report will be submitted to HealthCERT to consider my findings on the next audit of Te Whatu Ora Tairāwhiti's services.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Nurse Practitioner Ms Stephanie Thomson:

"I have been asked to provide an opinion to the Commissioner on case number C19HDC02091 on the care provided by nursing staff at Hauora Tairāwhiti for [Mr A] during his hospital admission from [Month1] to [Month3].

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a Nurse Practitioner with a scope of practice in adult perioperative care. Currently, I work as a Nurse Practitioner and am also the General Manager at Southern Cross Healthcare, Rotorua Hospital. I have been an RN and involved in perioperative and critical care in New Zealand and overseas since 1986.

I am not aware of any personal or professional conflict of interest in this case.

My instructions in reviewing this case were to comment on various aspects of [Mr A's] care and I will answer each individually with my recommendations at the conclusion.

1. **Hygiene concerns, including dress code. Please advise whether there are standards in place about uniforms and whether you have concerns about hygiene standards at Hauora Tairāwhiti based on the information available.**

It is difficult to make an opinion on the hygiene standards and dress code. The first set of photos showed clutter and general untidiness in one room, and while untidiness does not necessarily equate to a lack of hygiene it does raise the suspicion that adequate cleaning practices are not met. The family also describe an example and have a photo showing a used dressing being left on a chair for a period of time after a ward round. The written statements from the family describe uniform inconsistencies and the inability to distinguish the different roles within the healthcare team. According to [Ms C's] document, it is mentioned that the Director of Nursing is purchasing new uniforms for across the hospital for which I assume that this is necessary.

Untidy, cluttered patient care environments is not acceptable. Using the facts stated above, I would say this is a severe departure from acceptable standards. A peer group would take a dim view on clutter and untidiness. This sort of environment not only poses Infection Control challenges but can also contribute to patient falls and injuries.

The family's descriptions of 'a mismatch of uniforms' and that there is a plan for new uniforms across the hospital, leads me to believe that there is a lack of a uniform policy and/or adherence to that policy. While a high standard of tidy uniforms is desirable, the lack of, is a mild departure of accepted practice.

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2. Whether appropriate equipment was available and in an appropriate condition.

There were a number of examples provided by the family, of equipment that did not sound fit for purpose. Specifically, the tray that was cracked and the lack of supplying an extension for the patient's bed. The nursing note dated 06 [Month1] stated patient unable to be weighed due to not mobilizing. There was also the description of [Mr A] being placed in a treatment room/equipment storage room due to the shortage of beds. Lack of bed capacity is a real demand that hospitals face, however, I would expect a robust contingency plan for overflow beds. This plan would include ensuring the alternate bed space is cleared of extraneous equipment, adequate staffing and clear explanations and communication given to the patient and family.

The cracked tray and the lack of a bed extension is a severe departure from acceptable standard of care, and the lack of a suitable overflow room is a moderate departure. The inability to weigh a non-mobilizing patient is a severe departure from acceptable practice.

3. Expectations of privacy and how these are managed in a hospital setting. As part of this, please comment on the appropriateness, or otherwise, of the suggestion that patient notes should be kept at the end of the beds.

Under the Health Information Privacy Code 2020, a health agency needs to ensure that an individual's health information is kept securely to prevent loss, as well as prevent 'access, use, modification, or disclosure that is not authorized by the agency.' The code also states that a health agency does everything reasonable to prevent unauthorized use or disclosure of an individual's health information. In my opinion keeping medical records at the end of bed, although may demonstrate partnership and transparency with the patient, the obligation to keep records confidential cannot be met with any confidence.

4. Expectations regarding the role of nurses at meal times, and whether these were met in this case.

My expectation is that a Registered Nurse (RN) providing care for a patient utilizes their nursing judgement in order to ensure that a patient's health needs are met. This includes making sure that the patient has appropriate nutrition and fluids. According to the hospital's Surgical Services Standards of Care the patients 'receive the care and assistance that they require with eating or drinking', including 'special needs and restrictions are met.' A note dated 22 [Month2] at 1600 by [a] student dietitian and co-signed by […], confirm that the patient was not meeting daily caloric requirements and had an estimated 5 kg weight loss. Previous nursing notes document that [Mr A] required full assist with mobility. In the case of a frail patient with poor wound healing, diabetes, and dementia and at risk for aspiration I would expect more oversight from the nursing team with [Mr A's] meals. This could mean involvement from the family but there is no record of a discussion or agreement of how and to what extent that the family would be involved with the supervision at mealtimes and feeding. For example, there was a concerning nursing note (22 [Month2] at 2120hrs) where nursing recorded observing the wife having difficulty feeding [Mr A] and frustration evident from both

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[Mr and Mrs A]. The note did not include any nursing intervention or assistance. I reviewed the nursing notes and found no documentation of an admission weight, weight throughout his stay or planned interventions to ensure [Mr A] received assistance with his meals. This is a severe departure from acceptable standards and inconsistent with Hauora Tairāwhiti's own Standards of Care.

5. The coordination of care between Hauora Tairāwhiti and Waikato Hospital. Was handover appropriately managed? Was the right information communicated to nursing staff?

I was unable to find any nursing transfer documentation from Hauora Tairāwhiti to Waikato Hospital. There is a nursing transfer letter from Waikato Hospital to 'Gisborne Hospital' dated 25 [Month1] giving minimal information regarding [Mr A's] care.

Transfer of care is one of the highest risk times for patient safety due to information possibly being omitted or misunderstood. I found the nursing transfer documentation between both organizations unsatisfactory and put [Mr A] at risk. This is a moderate departure from acceptable practice.

6. Coordination between teams within Hauora Tairāwhiti — such as, between doctors and nurses, within nursing teams.

There are chronological notes showing nursing notes every shift and doctors notes on a daily basis. There is no indication that there was meaningful discussion between the different aspects of the team members involved in [Mr A's] care. Despite his extremely long length of stay, deteriorating medical condition, multiple co-morbidities, family concerns and complex discharge disposition there was no evidence of co-ordination or collaboration between the multi-disciplinary team members and family members particularly the EPOA and wife. This is a severe departure from acceptable practice. Not having clear documentation from a multi-disciplinary team meeting with realistic patient focused goals would not be acceptable by my peers.

7. Whether [Mr A's] wounds were managed appropriately. As part of this, please comment on whether dressings were changed at appropriate intervals, and whether options for pressure supports were appropriately considered.

The Hauora Tairāwhiti wound documentation was incredibly difficult to decipher. There were no objective measurements of the various wounds, no clear description of the wounds, their cause and where they were. Instructions for type of dressings and timing of dressing changes could not be found. I cannot form an opinion regarding the management of the wounds or frequency of dressing changes as I cannot tell from the record with any confidence what the management of the wounds was.

Due to the restless legs of the patient and the concerns from the family about [Mr A] hitting his feet on the end of the bed, the use of foot pressure supports could have been helpful if introduced earlier. However, there is an argument that using pressure supports such as a foam boot can increase the pressure and shear/friction on a

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vulnerable area. Therefore, not using a foam boot could have been a reasonable nursing decision at the time.

8. Whether [Mr A's] incontinence was managed appropriately.

[Mr A] was incontinent of urine at home so the urinary incontinence was not a new issue, but it appears the groin excoriation was. From reviewing the nursing notes, it seems [Mr A's] incontinence pad was changed at least once if not twice a shift. There are frequent notations of [Mr A] having a full bed bath on a regular basis. It is noted that his groin was described as reddened soon after admission (09 [Month1]) and barrier cream being initiated. By the 15 [Month1] his groin was now reported to be excoriated. It is disappointing to see that alternative methods to maintain skin integrity were not attempted earlier e.g uridome. This was eventually attempted after his return from Waikato but despite ongoing, multiple attempts over a number of days was clearly not effective. There was no mention of a continence nurse referral until 2 [Month2] and there was no discussion documented between the nursing team and the medical team about assessment and interventions to manage his incontinence and ongoing skin integrity. There was no planned toileting attempted which may have prevented faecal incontinence, or discussion around the short term use of a catheter or intermittent catheterization. An antifungal cream was not prescribed until 21 [Month2], this would have been helpful started much earlier after his admission in light of the antibiotics he was requiring and previous history of groin thrush. Although [Mr A's] incontinence was managed with regular changing of pads, there was no evidence of nursing escalation of concern despite reading note after note that his groin was getting worse. This is a severe departure of accepted practice.

9. Whether the wound on the back of [Mr A's] head was appropriately managed.

There is a brief mention of a 'lump L) back of head' with the notation 'seems less with it today.' 'unwitnessed trauma, N+ V ?' in a ward round note on 1 [Month2]. There is no further follow up such as neuro checks, investigation into how the lump occurred or open communication to the family. According to an undated/untimed note, patient was waiting for a Head CT. There is no result documented in ongoing medical notes, nor any further mention of medical neuro assessment or follow up. Despite the possibility of an unwitnessed trauma and the patient also being a high falls risk, no additional nursing interventions were put into place such as intentional rounding or a sitter. There is a severe departure of accepted practice in the medical follow up of the CT scan, communication to the EPOA of the results and also with the lack of responsiveness from the nursing team to ensure [Mr A's] ongoing safety.

10. The drain removal incident.

The documentation around the drain removal and the subsequent major bleeding that followed indicates that prompt and appropriate treatment was given by the nursing staff. On removal of the drain, there was a major bleed. He received a rapid response from the 777 team, pressure applied, PRBC ordered and a surgeon to review. He received a unit of PRBC approx. 2 hours after the incident (which is a reasonable time frame as active bleeding had halted, he remained hemodynamically stable and a cross

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match needed to be done) and later he was taken to theatre for exploration, a clot was evacuated and it was not an arterial bleed as initially thought. From what I read, I would say that the care and response was satisfactory.

11. Whether pain relief was managed appropriately.

On reviewing the Adult Vital Sign Chart, the pain scores were invariably left blank or had a tick which I am not sure what that meant. There were notations throughout the nursing record of patient appearing in pain, or family reporting pain and it was documented he had pain relief administered. It was difficult to tell what analgesia he had administered from the way the National Medication Chart was photocopied. However, it appears he had 2–3 doses paracetamol a day when it was prescribed QID. He received oxycodone 5mg mane as prescribed for a period of time, and it appears he had oxycodone 10mg CR nocte added into his regime in late [Month1]. Between 26 [Month1] and 30 [Month1] he received prn doses of Oxycodone IR 5–10mg, and I am unable to tell if he had more of this during his stay. He also received a short trial of gabapentin which I believe was discontinued due to drowsiness. Many pain relief medications would be unsuitable for [Mr A] due to his renal insufficiency, and the use of opiates challenging due to his mentation and intermittent drowsiness. Using the information I have available I would say his pain was not managed extremely well, but I do acknowledge that this was a challenging situation. To that end I would say his pain management is a moderate departure from acceptable practice.

12. Whether appropriate action was taken in response to [Mr A's] heel infection.

[Mr A] had a necrotic L) heel on admission. Due to his peripheral vascular disease, this had very little chance of healing. Attempts were made to debride it, and revascularization was unsuccessful. I believe it was inevitable that [Mr A] would require an amputation unless a palliative treatment plan had been initiated. I cannot see where there was a realistic prognosis and options proposed to the family related to the likely outcome of [Mr A's] necrotic foot and his co-morbidities. This is a severe departure from acceptable practice.

13. Whether [Mr A's] type 2 diabetes was managed appropriately.

[Mr A] Blood Sugar levels (BSLs) were checked on a regular basis and fluctuated between 3.8–15 mmol/L. As far as I can tell he received his oral hypoglycaemic as prescribed. Staff responded appropriately when his BSL was low and gave orange juice. His diet was somewhat compromised due to his mentation. His management of his diabetes was reasonably managed.

14. The adequacy of communication with the family.

There is scant documentation in the medical record of discussions and communication with the family. [Mr A] was at the end stage of his life and his condition was deteriorating. The opportunity for the EPOA and the wife to choose a palliative treatment plan was not offered. There was some Social Work involvement where the focus was discharge planning to home which was unrealistic. Considering [Mr A] had

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over 9 weeks in hospital, I think there should have been regular family meetings updating the EPOA and wife of [Mr A's] condition and treatment plan.

15. Discharge — appropriateness of discharge, communication with family regarding discharge, information provided on discharge.

There was lack of direction as well as MDT coordination regarding the discharge planning. Initially, the discharge disposition was to return home even though the wife stated that [Mr A] was becoming more and more difficult to manage and had injured herself helping the caregivers transfer him. Mrs A also stated on admission to the Social worker that she could only take [Mr A] home if he was mobile. It should not have taken nearly 2 months to come to the decision that [Mr A] would not be able to return home, even with additional home help. There was a lack of responsiveness and discussion with the family around realistic options for [Mr A]. I understand that this would have been a challenging conversation, and due to the difficulty of these conversations, they are often avoided, but not doing so, is a moderate to severe departure of acceptable practice.

16. Any other matters in this case you warrant comment or amount to a departure from accepted nursing practice.

My overall impression of the care that [Mr A] received at Hauora Tairāwhiti was that there is a team of staff who are under resourced. There was a lack of coordination and leadership between the various team members and his treatment plan. Although there were regular nursing notes reflecting [Mr A's] basic needs were taken care of, there was a distinct lack of nursing leadership and patient advocacy. The Care Plan was a simplified document that did not add value to the care of [Mr A]. Nurses are at the bedside more than any other health care professional, but I sensed there was no therapeutic relationship, trust or empathy between the nursing staff and [Mr A] and his family.

My recommendations in no particular order of relevance:

1. If there is a uniform policy, for this to be circulated and ensure that staff are aware of the policy and adhere to it. If there is not such a policy, then one needs to be put into place.

2. A review of patient care equipment (e.g patient care tables) needs to be undertaken and unsafe equipment taken out of circulation. Any equipment not available (i.e bed scale) needs to be noted and consideration for purchase.

3. An evaluation of the process of how to deal with a tight bed situation and where to temporarily house patients in a suitable, safe and functional environment.

4. A process to elicit patient and whānau feedback in order to ensure the needs of patients and whānau are being met and to allow for on-going continual improvement of the delivery of nursing care.

5. There needs to be a more robust nursing transfer process from Hauora Tairāwhiti to other organizations that ensures the patient has a seamless transition and ensures

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continuity of care. This may or may not involve a verbal handover between nursing staff.

6. The documentation for the status and treatment of wounds needs to be reviewed. I would suggest at least, that measurements are taken on wounds, and photos taken to ensure that progression or deterioration is clearly documented.

7. The procedure for nursing referrals needs to be strengthened. For example, the continence CNS should have been involved sooner, a pain service referral may have been helpful, a gerontology consult could have been requested, and earlier involvement from a dietitian would have been beneficial.

8. MDT meetings need to be held on a weekly or at a bare minimum, on a fortnightly basis. Clear documentation around the outcome and goals of care from these meetings. These then need to be communicated and discussed with the patient, and if appropriate to include the whānau.

9. A review of nursing documentation that supports patient centred care and demonstrates nursing assessment, intervention and evaluation. e.g using the SOAP or equivalent format."

The following further advice was obtained from Ms Thomson:

"Thank you for forwarding the response from Hauora Tairāwhiti. I have read [Ms C's] comments and have had a chance to relook at the medical record of [Mr A]. I appreciate the opportunity to review my advice and make any changes.

Hygiene concerns, including dress code.

[Ms C] confirms that the uniforms have been replaced throughout the DHB, and I saw the Nurse and Healthcare Assistant Dress Code had been reviewed in August 2020 and the Dress Code for Hauora Tairāwhiti which was reviewed in January 2021. With this in place I'm sure the nursing leadership will ensure the uniform code is adhered to.

I maintain that a cluttered and untidy patient care environment is unacceptable. I accept [Ms C's] comments that [Mr A] was initially in a treatment room that also housed some equipment. What is not clear is the question on whether this area was kept tidy and uncluttered. I based my opinion on photos and descriptions from the original complaint. I would be more convinced that this was an isolated incident if Hauora Tairāwhiti could objectively report on-going tidy, clean patient care areas with routine audits and quality checks.

Whether appropriate equipment was available and in an appropriate condition.

[Ms C] states that there were seated scales and wheelchair scales available although at a distance to the ward. I agree with her comment that some assessments may be delayed on admission; however it remains a severe departure of practice that [Mr A] was not weighed throughout his stay until his transfer when it was required for fuel calculations for the flight transfer. When it had been noted that the patient had an

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estimated 5 kg weight loss and was not meeting caloric requirements, I would expect a weekly weigh would have been appropriate.

I appreciate [Ms C's] explanation of the bed extension and removing the foot of the bed was a sensible thing to do to avoid injury. I understand delays in supply and a capital replacement programme, but a cracked over bed tray can have significant infection control consequences so should have been taken out of circulation.

Expectations regarding the role of nurses at meal times

I agree with [Ms C] that there are scattered comments throughout the nursing notes regarding [Mr A's] meals and his intake. Often the wife and daughter were assisting him with his meals which is excellent. However, there is no comprehensive record of his dietary intake to ensure that from day to day he was receiving adequate calories and fluid. After reading [Ms C's] response, I agree that there was some nursing awareness of [Mr A's] nutritional intake, but remain of the opinion that there was not a comprehensive, consistent approach to his dietary and nutritional needs, including at least weekly weighs which I find a severe departure from acceptable practice.

Coordination of care between Waikato Hospital and Hauora Tairāwhiti

I rescind my comments around the handover and coordination of care after being able to read the flight nurse's documentation. This showed a detailed assessment and handover to receiving ward nurse.

Coordination of care between the clinical teams at Hauora Tairāwhiti

I appreciate [Ms C's] comments. My opinion remains unchanged.

Wound management

No further comments.

Management of incontinence

No further comments.

Head wound

No further comments.

Pain management

No further comments.

Management of heel wound

No further comments.

Discharge Planning

No further comments.

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I have not amended my recommendations at this time, except for removing recommendation 5 regarding the transfer between Hauora Tairāwhiti and Waikato Hospital as the flight nurse documentation was robust and comprehensive.

Please do not hesitate to contact me if further information or explanation is required."

The following further advice was obtained from Ms Thomson:

"Thank you for sending through the additional reports and documentation from Tairāwhiti. I have reviewed them and please see below my responses to your 3 questions.

1. Does this new information change the advice you provided previously to the Commissioner and, if so, how?

1. Uniform policy: Tairāwhiti has stated in their correspondence to you that the roll out of the new uniform has been completed which is excellent.

2. Patient care equipment: The Health and Safety Audits were done every 2 months and I saw the audits to [Month2]. The one completed in [Month2] did identify cracked bedside tables. The audits also noted that there were 2 bedside lamps that needed repairing for 8 months. So I see evidence that the items are identified, but no clear process or follow up that items identified are actioned. There was also a June Environmental Audit Summary 2019 which again identified issues in the environment but no clear process of who and when would follow through on these items.

So there is no change in my recommendation listed as point 2 in my response 2nd March 2021.

3. Tight bed situation: I reviewed the Variance Response System which is focused on staffing requirements and not particularly relevant to the tight bed situation. My response from 3rd February 2022 had concerns on whether the treatment room that initially housed [Mr A] was clean, tidy and appropriate. From reviewing the monthly Housekeeping Audits for 2019, it appears that overall the housekeeping standards were maintained. After seeing these, if the treatment room had been clean and tidy as reflected in the audits, then I would agree that using the treatment room would be a suitable, temporary bed assignment in a tight bed situation.

4. Kōrero mai programme: Good to see this programme has been implemented to encourage and reduce barriers from patients and whānau to report concerns.

5. Transfer process: Already discussed

6. Wound documentation: I see the district nursing photos and documentation prior to [Mr A] being admitted to hospital, which I presume was part of the medical record for [Mr A] while he was an in-patient. I also, have now seen the Wound CNS documentation in the progress notes, however still find the wound charts difficult to read, track status

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of the wounds and they were incomplete. I personally would want to see this documentation reviewed and streamlined, and made more ‘user friendly’.

7. Nursing referrals: No change from my recommendation from 3rd February 2022.

8. MDT meetings: No change from my recommendation from 3rd February 2022.

9. Nursing documentation: No change from my recommendation from 3rd February 2022.

2. Were the policies, procedures, forms, and checklists provided by Tairāwhiti that were in place at the time [Mr A] was in Gisborne Hospital appropriate and sufficient?

I have seen a number of Infection Control audits, housekeeping audits and health and safety audits. Not all were dated at the time of [Mr A’s] admission. Those that I saw were comprehensive, however, there was a theme that there was no ‘closed loop’ and although issues were identified, there was no clear process on how or who was going to action them. E.g June Environmental Audit Summary 2019, Hazard identification Checklist January–[Month2].

3. In as far as you can determine from the information provided, are the policies, procedures, forms, and checklists that Tairāwhiti have in place now appropriate and sufficient and, if not, what is lacking?

a) Follow up process for tracking and accountability of completing action items.

b) Streamlined, comprehensive wound assessment and treatment documentation.

c) Process for ensuring MDT communication and discussion is taking place routinely.

d) A review of how nurses document in the progress notes i.e patient centered and focussed.

Please do not hesitate to contact me if further information or explanation is required.”

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