A Rest Home

Registered Nurse, RN C

Registered Nurse, RN D

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC01286)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A, aged 90 years, was a resident at a rest home facility that also provides hospital-level care. In 2012, registered nurse (RN) C was the facility manager and RN D was the clinical manager. Mrs A's care and treatment was documented in four different locations: a progress report, a care plan, a wound care record, and a registered nurse communication diary.

2. On 2 Month1[1] 2012, Mrs A had a skin cancer lesion removed from her lower left leg at a public hospital (the Hospital). Mrs A was discharged back to the rest home on the day of the surgery. The discharge summary stated that Mrs A should stay in the hospital wing of the rest home. Follow-up was arranged for Mrs A at the Hospital's outpatient plastics clinic.

3. On Mrs A's return to the rest home, RN E did not implement a new care plan for Mrs A.

4. Despite the recommendations in the discharge summary, Mrs A remained in her room in the rest home wing, as there were no available beds in the hospital wing. Between 2 Month1 and 14 Month1, Mrs A continued to have follow-up at the outpatient plastics clinic with regard to her wound care. From 14 Month1, Mrs A's wound care was undertaken at the rest home. From 25 Month1, Mrs A's condition began to deteriorate.

5. On 28 Month1, a swab was taken from Mrs A's wound site and sent to microbiology. The results indicated an infection, and general practitioner Dr H prescribed antibiotics for Mrs A. There is no record that either Mrs A or her daughter, Mrs B, were informed that Mrs A had an infection. Between 16 and 30 Month2, the condition of Mrs A's wound deteriorated further, with discharge noted.

6. On 4 Month3, Mrs B found Mrs A in her room in a confused and distressed state. RN C reviewed Mrs A at Mrs B's request, and told HDC that she sent a fax to Dr H requesting a review of Mrs A's leg. There is no record of RN C's assessment of Mrs A on 4 Month3 or of a fax sent to Dr H at that time. Dr H visited the rest home that afternoon but he did not review Mrs A, as her leg had just been dressed that day and he was scheduled to visit her two days later.

7. On the morning of 5 Month3, Mrs A was again confused and disorientated, and had slurred speech and visible right-sided drooping of her mouth. RN C assessed Mrs A and considered that she had had a stroke. RN C told HDC that she sent a fax to Dr H requesting him to attend. There is no record of a fax being sent to Dr H at that time.

8. An enrolled nurse telephoned Mrs B and advised her that Mrs A was unwell and that Dr H had been contacted. At 12.30pm Dr H assessed Mrs A and arranged her transfer to the Hospital.

9. The medical team at the Hospital concluded that Mrs A had overwhelming sepsis and pneumonia (not related to the infection discovered after the 28 Month1 swab). On 12

[1] Relevant dates are referred to as Month 1 – Month 3 to protect privacy.

Month3, the medical team withdrew active treatment for Mrs A, and she died on 15 Month3.

Findings

The rest home

10. The rest home's documentation of Mrs A's care and treatment did not meet the New Zealand Health and Disability Sector Standards, and fell well below an acceptable standard. Accordingly, the rest home breached Right 4(2)[2] of the Code of Health and Disability Services Consumers' Rights (the Code). The rest home also failed to ensure that Mrs A received clinical care that was of an appropriate standard and complied with the Code. Accordingly, the rest home breached Right 4(1)[3] of the Code.

11. Adverse comment was made with regard to the rest home's responsibility for its staff's communication with Mrs A and her daughter, Mrs B, as her primary contact person.

RN C

12. RN C failed to ensure that staff at the rest home provided adequate care and treatment to Mrs A. Furthermore, RN C personally failed to provide services to Mrs A with reasonable care and skill. Accordingly, RN C breached Right 4(1) of the Code.

13. RN C also failed to ensure that staff at the rest home complied with policy and professional standards with regard to documentation. Furthermore, RN C personally demonstrated a failure to comply with professional standards in respect of her documentation. Accordingly, RN C breached Right 4(2) of the Code.

14. Adverse comment was made about RN C in her role as facility manager, with regard to the failure of staff at the rest home to communicate adequately with Mrs B on 5 Month3.

RN D

15. RN D failed to ensure that Mrs A received adequate clinical care with regard to her wounds. Accordingly, RN D breached Right 4(1) of the Code.

16. RN D also failed to ensure that staff at the rest home complied with policy and professional standards with regard to documentation. Furthermore, RN D's individual standard of documentation was not always adequate. Accordingly, RN D breached Right 4(2) of the Code.

17. Adverse comment was made about RN D in her role as clinical manager with regard to the failure of staff at the rest home to communicate with Mrs A regarding the infection in her leg.

[2] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[3] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

RN E

18. Adverse comment was made with regard to RN E's failure to implement a wound care plan when Mrs A returned from surgery on 2 Month1.

Complaint and investigation

19. The Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs A, by the rest home. The following issues were identified for investigation:

- *Whether the rest home provided an appropriate standard of care to Mrs A between Month1 and Month3 2012.*
- *Whether RN C provided an appropriate standard of care to Mrs A between Month1 and Month3 2012.*
- *Whether RN D provided an appropriate standard of care to Mrs A between Month1 and Month3 2012.*

20. An investigation was commenced on 20 September 2013. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

21. The parties directly involved in the investigation were:

Mrs B	Complainant
The rest home	Provider
RN C	Facility manager and registered nurse
RN D	Clinical manager and registered nurse

22. Information was also reviewed from the following parties during the investigation:

RN E	Registered nurse
EN F	Enrolled nurse
Ms G	Kitchen/service staff
Dr H	General practitioner
Dr I	Plastic surgeon
District Health Board	Funder

Also mentioned in this report:

RN J	Rest home director

23. Independent expert advice was obtained from a registered nurse, Jan Grant (**Appendix A**).

Information gathered during investigation

Overview — Mrs A

24. Mrs A, aged 90 years at the time of these events, was a resident at the rest home. Mrs A normally required some assistance with daily living activities such as dressing, bathing and showering, and used a walking frame for mobility. She had good communication and was able to eat and drink independently. Mrs A had a history of multiple skin cancer lesions on her face, and a lesion on her lower left leg.[4] Mrs A had previously had biliary sepsis,[5] for which she was on long-term antibiotics (Augmentin). Mrs A's daughter, Mrs B, visited Mrs A frequently at the rest home.

The rest home

25. The rest home provides rest home-level care and hospital care. Mrs A resided in a room in the rest home wing.

The rest home's Resident Admission Agreement

26. On admission to the rest home in November 2008, Mrs A signed the Resident Admission Agreement. The Agreement stated at paragraph 4.3:

> "The Resident will provide [the rest home] with the names of the Resident's family members or a nominated representative. [The rest home] may use this information to maintain contact with the Resident's family member or nominated representative for the purposes of this agreement …"

27. On Mrs A's admission document Mrs B was named as Mrs A's "next of kin/advocate" and was also listed as the "person to be contacted in an emergency". Mrs B also signed a "Personal details update form" stating that she wished to be contacted if her mother had a minor injury or accident.

28. The "Communication with Families" policy in place at the time of these events stated:

> "It is important to ensure that the nominated contact person is kept informed with all relevant information regarding the well-being of their loved one … A record of all communication is recorded on the Communication Record Sheet and where necessary in the progress notes."

Staff at the rest home

RN C — facility manager

29. In 2012, RN C was the facility manager holding overall responsibility for managing the rest home.[6] According to RN C's job description valid at the time of these events, her key responsibilities included:

[4] In 2011, Mrs A underwent radiation therapy for treatment of the lesions on her face. She did not undergo radiation treatment for the lesion on her leg at that time, owing to the "high risk of causing a longstanding radio-necrotic ulcer".

[5] Inflammation of the biliary system as a response to an infection.

[6] RN C was employed by the rest home and had been working at the rest home since 2007 (but was not employed as an RN at that time). RN C advised HDC that she commenced the role of facility manager in October 2011, and this was her first role as a facility manager in aged residential care. She stated that her orientation to the role at the rest home was limited.

> "The general day to day running of the facility and all staff employed. The Manager is required to take responsibility (individually or jointly with the General Manager and Directors), to … set and maintain high standards of professional practice and create a caring environment conducive to the individual … needs of each resident; to ensure each resident receives care according to need … and to supervise all staff employed in the Home.
>
> …
>
> 1. Resident Care — Ensure a high standard of care is delivered in accordance with an individual resident's care plan … Liaise with visiting Consultants, GPs community nurses, Social Workers etc … Liaise closely with relatives giving support and comfort where appropriate.
>
> 2. Staffing — The recruitment, appointment, induction, motivation, monitoring and support of staff to ensure they achieve company standards and the highest level of care within the latest employment requirements."

30. In addition, RN C advised HDC that she "still like[s] to do some shifts on the floor" but that it is rare for her to do so.

RN D — clinical manager

31. In 2012, RN D was the clinical manager at the rest home.[7] RN D had overall responsibility for the clinical care provided to residents at the rest home. As part of her role, RN D was required to supervise the registered nurses and caregivers and ensure that safe and professional nursing care was delivered. RN D advised HDC that her role often included "working on the floor".

32. According to RN D's job description valid at the time of these events, her responsibilities included:

> "1. … Where possible residents and their families are involved in planning care and decision making related to nursing care.
>
> Care is carried out according to medical orders and Nursing Care Plan.
>
> Standards for nursing practice are met.
>
> …
>
> 2. To maintain documentation of resident care and health status.
>
> Each resident has a documented nursing assessment and Nursing Care Plan.
>
> Nursing Care Plans are evaluated and updated at least every three months and as necessary.
>
> Nursing progress notes are written at least twice weekly and when necessary for each resident.

[7] RN D was employed by the rest home, and had been working at the rest home since 2007.

…

3. To supervise Care Staff using a team approach ensuring their nursing practice meets required standards. Obtains a report of each Resident's condition/health status prior to each nurse completing duty/shift. Give direction and delegate duties to maintain harmonious environment and realistic workload …"

Documentation at the rest home

Documentation policy

33. The rest home's documentation policy relevant at the time of these events stated:

"Documentation at the facility will be objective and accurate.

…

The registered Nurse in charge of the duty will stamp each resident's file with their personalised stamp, which has on it their name and nursing council number.

…

Documentation in residents' integrated files will be completed prior to leaving at the end of the day.

…

Documentation in integrated clinical records will be audited as required by internal and external audits.

…

It is the responsibility of all nursing staff to:

Complete all documentation for residents they have cared for during that day's shift prior to leaving the facility at the end of their duty …"

34. Methods of documentation that were used to record Mrs A's care and treatment at the rest home are summarised below.

Progress report

35. The progress report is the most comprehensive of Mrs A's notes. The progress report includes information about Mrs A's general state of health, communication with and visits from family, and brief details regarding Mrs A's wound care.

Care plan/progress and evaluation notes

36. Mrs A's care plan is dated 16 November 2011 and is headed "Resident's Problem/need, Skin Cancer L) [left] lower leg". The care plan includes information about Mrs A's appointments outside of the rest home, communication with Mrs A's general practitioner (GP), and brief notes about wound care.

Wound care record

37. The wound care record includes dates on which Mrs A's wounds were redressed, as well as brief descriptions of the condition of Mrs A's wounds.

RN communication diary

38. Staff kept a communication diary which contained information regarding the rest home's residents.[8] The registered nurse communication diary includes very brief notes about communication between staff at the rest home regarding its residents. Information with regard to Mrs A includes dates of appointments and notes regarding staff communication with her GP.

Wound care policy at the rest home

39. The wound care policy relevant at the time of these events required:

> "Full documentation of any dressings applied to the wound or skin tear and changes to the short term care plan as appropriate.
>
> …
>
> Ongoing analysis of … residents' physical environment and health status to prevent further skin tears and skin breakdown.
>
> …
>
> All residents have individual care plans for all wounds, which are evaluated a minimum of 2 weeks or sooner as required.
>
> …
>
> Referrals to GP or wound care specialist are made as required.
>
> …
>
> All care staff responsible for assessing and dressing wounds receive ongoing training and supervision in:
>
> - Wound care dressing.
> - Infection control.
> - Appropriate documentation.
> - Analysis and prevention.
> - Data collection and benchmarking."

2 Month1 — Mrs A's surgery and discharge from Hospital

40. On 2 Month1, Mrs A had a skin cancer lesion removed from her lower left leg under local anaesthetic at the public hospital. Mrs A's surgery involved a graft being taken from a donor site on her left thigh. This meant that Mrs A had two wounds following her surgery — at the graft site (the main wound on her lower left leg) and at the donor site (on her upper left thigh).

41. Mrs A was discharged back to the rest home on the day of the surgery. The discharge summary with regard to Mrs A's management states:

> "1) Regular analgesia;

[8] Information regarding residents at the rest home other than Mrs A was redacted by the rest home prior to sending the diary to HDC.

2) Complete course antibiotics;

3) Elevate left leg, strict bed rest 5/7. Up to toilet 1–2 [times] day only [emphasis in original];

4) Contact GP if any concern;

5) Advise staying in hospital wing of rest home as unable to mobilise for 5/7."

42. In addition, it is noted on the discharge summary that Mrs A should be seen by plastic surgeon Dr I at the Hospital's outpatient plastics clinic five and ten days after discharge respectively, and again three to four weeks after discharge. At the bottom of the discharge form it is noted:

"6) Do not disturb Donor Site

7) Reinforce [with] tegaderm[9] if leakage

8) If tegaderm becomes over filled [with] ooze this can be aspirated[10] and resealed."

43. The rest home told HDC that the instructions numbered 6) to 8) were added following a phone call to staff at the rest home from a registered nurse at the Hospital after Mrs A returned to the rest home. However, there is no documentation regarding when this note was added, or who it was written by.

Return to the rest home post-surgery

44. Mrs B brought Mrs A back to the rest home on the evening of 2 Month1. On her return, Mrs A was assessed by RN E, who told HDC that Mrs A's leg was "heavily bandaged". RN E said that this was unexpected, as her impression had been that the procedure would be relatively minor. The rest home advised HDC that Mrs A's operation had been lengthier than first envisaged, and that staff at the rest home did not receive any warning from the Hospital that "extra care" would be required for Mrs A.

45. The rest home advised HDC that, despite the advice in the discharge summary that Mrs A should stay in the hospital wing, she remained in her room in the resident's wing as there were no available beds in the hospital wing.

46. RN E told HDC that when Mrs A returned to the rest home, she explained to Mrs A and Mrs B the importance of bed rest and elevation of Mrs A's leg, as per the discharge instructions from the Hospital. RN E said that she emphasised to Mrs A that she must not mobilise on her own and must ring for assistance. RN E noted in the progress report: "[L]eg elevated on pillow, stressed the importance of bedrest, otherwise leg bandage intact."

47. RN E and enrolled nurse (EN) EN F both told HDC that, despite RN E's advice not to mobilise, Mrs A frequently walked unassisted to the toilet, after arriving back at the

[9] A wound dressing made by 3M Products.
[10] To withdraw fluid with a syringe.

rest home following her surgery. RN E told HDC that she again advised Mrs A of the importance of requesting assistance, but Mrs A continued to mobilise independently. There is no documentation regarding Mrs A mobilising independently on 2 Month1.

48. No new care plan was initiated or implemented and, although the procedure was recorded on Mrs A's care plan, no amendments were made to the existing care plan with regard to wound care.

49. It is recorded on Mrs A's care plan document: "Area excised and skin graft from upper L thigh." This note is dated 2 Month1 and signed by RN D. However, despite appearing to have filled out and signed that documentation on 2 Month1, RN D advised HDC:

> "I can confirm that I was not on duty on 2 [Month1]. I came on to a morning shift on 3 [Month1], and upon seeing that Senior Registered Nurse, [RN E] had not instigated a care plan or documented the procedure, I rectified this by writing the 2 [Month1] as this would allow for sequential documenting. I put the 2 [Month1], as that was the date of her surgery."

50. RN D advised HDC that, as there were no beds available in the hospital wing, on 3 Month1 Mrs A's usual bed was swapped for an "older style hospital bed" that had become available.

51. In response to the provisional opinion Mrs B told HDC that on 3 Month1 she visited her mother and was advised by a staff member at the rest home that Mrs A had been getting out of bed and going to the toilet. Mrs B told HDC:

> "I told mum that she was on bed rest and was to stay in bed and ring the bell if she needed to go to the toilet, and she said they don't come when I ring the bell."

52. Progress notes on 5 and 6 Month1 record that Mrs A's dressing remained "intact" and that there was "nil leakage".

53. In notes on 3, 4, 5, 6 and 7 Month1 it is recorded that Mrs A was assisted to the toilet several times by staff. On 3 and 5 Month1 it was recorded that Mrs A sat on her walking frame in order to be assisted. However, on 7 Month1 it is noted: "[Up to toilet] 3x … walked to and from toilet several times."

8 Month1 — first follow-up appointment at the outpatient plastics clinic

54. On 8 Month1, six days postoperatively, Mrs A was reviewed at the outpatient plastics clinic. On her return to the rest home, the following was noted in Mrs A's progress report with regard to that appointment:

> "To [Hospital] … graft … redressed … to be redressed in 3 days … Donor site — this dressing to be removed in 3 to 4 days. Leg is to be kept elevated as much as possible please."

10 Month1 — second follow-up appointment at the outpatient plastics clinic

55. On 10 Month1, eight days postoperatively, Mrs A had a second follow-up appointment at the outpatient plastics clinic to have her wounds assessed and redressed. The assessment and progress notes from the clinic state that Mrs A was on antibiotics[11] and that there were "no obvious signs of infection". The notes also state that both the graft and donor sites should be reviewed in three to four days, and that Mrs A should keep her leg elevated to assist blood flow. The care plan was updated by RN D to state: "Returned to surgical clinic for [removal of] clips and sutures. Dressings to be changed 3–4 daily."

56. It is noted in the registered nurse diary on 10 Month1: "[Mrs A's] bed to be swapped with Room [X]." RN D told HDC that on 10 Month1, Mrs A's bed was changed again, this time for an electric hospital bed.

11 Month1 — Mrs A's first fall at the rest home

57. On 11 Month1, it is recorded in Mrs A's progress report that she had fallen while trying to get out of her chair. It is further noted: "No injuries sustained, [Mrs B] notified." On 12 Month1, it is stated: "nil affects post fall".

58. There are no records regarding Mrs A's wounds between 11 Month1, and 13 Month1.

14 Month1 to 22 Month1 — wound care at the rest home

59. On 14 Month1, 12 days postoperatively, Mrs A's wounds were examined and redressed by RN D. The care was recorded in Mrs A's wound care record noting that her wounds should be reviewed again on 18 Month1. The rest home confirmed that this was the first time its staff reviewed Mrs A's graft site following her surgery. The rest home advised that its staff did not review Mrs A's wounds prior to this date as Mrs A's wounds were being cared for by staff at the outpatient plastics clinic.

60. On 16 Month1 Mrs A's wound care record states: "Dressings checked for ooze. Remain intact."

61. On 17 Month1, RN D redressed Mrs A's wounds and updated the care plan noting: "Initial dressing, area excised extensive approx. 6cm x 1.5cm deep. Skin layering base appears bruised & surrounding area inflamed." It is recorded in the progress report: "Dressing intact." RN D recorded in the wound care record that the wounds should be reviewed again on 20 Month1.

62. On 20 Month1, it is noted in the progress notes: "Leg dressing weeping"; however, there is no record that Mrs A's wounds were redressed until 22 Month1. On 22 Month1 it is noted in the progress notes: "[L]eg redressed." Also on 22 Month1, the rest home's facility manager, RN C, telephoned the district nurse at the Hospital, who confirmed that staff at the rest home had been using the correct dressings on Mrs A's wounds.

[11] As stated above, Mrs A had previously had biliary sepsis and was on long-term antibiotics.

25 Month1 to 14 Month2 — deterioration of Mrs A's graft site and physical condition

63. On 25 Month1, 23 days postoperatively, Mrs A's GP, Dr H,[12] recorded in the medical notes[13] that he attended Mrs A for a regular three-monthly review. Dr H recorded: "Had excision 3 weeks ago. Skin graft hasn't taken. Large wound. — dressings — review in a few weeks. Bp 105/80 pulse reg chest clear." It is noted in Mrs A's wound care record that Mrs A's graft site was redressed.

64. Mrs A's progress report states: "[Dr H] … Skin Graft to L/leg [has not] taken. Swab to be sent to lab [M]onday. Will review in a few weeks." Mrs A's wound care record states: "[P]urulent[14] ooze from graft site, surrounding area inflamed." Mrs A was given 50mg tramadol[15] for "painful legs".

65. Approximately three weeks after Mrs A's operation, Mrs B and her husband, Mr B, visited Mrs A at the rest home. Mrs B told HDC that she noticed that her mother was sleeping during the day, which was unusual for her. Mrs B told RN D that she was concerned that Mrs A was sleeping more than usual and appeared unsteady on her legs.

66. RN D said to Mrs B that Mrs A was "not as young as she used to be" and she had just had major surgery, which was taking a toll on her. There is no record of this conversation between RN D and Mrs B, and Mrs A's care plan was not updated.

67. On 28 Month1, a swab was taken from Mrs A's graft site and sent to microbiology, as instructed by Dr H. RN D recorded in Mrs A's care plan: "Swab taken: area mod green ooze. [N]il odeur [sic] …"

68. On 30 Month1, RN D noted in the wound care records: "Large purulent discharge/sloughy … purulent ooze from graft site."[16] Late in the afternoon on 1 Month2, the rest home received Mrs A's lab results by fax, but these were not reviewed at that time. On the morning of 2 Month2, a registered nurse reviewed Mrs A's results, which indicated a methicillin-resistant *Staphylococcus aureus* (MRSA)[17] infection. On 5 Month2, it is recorded in the communication diary: "ABS[18] for MRSA — GP faxed." On 7 Month2, Dr H prescribed Deprim[19] twice daily for Mrs A.[20]

69. Mrs B advised HDC that staff at the rest home never informed her that Mrs A had an infection. RN D advised HDC that Mr and Mrs B visited Mrs A "most days", and that

[12] Dr H is a vocationally registered general practitioner.
[13] The medical notes are recorded by the visiting GP, but are kept on the patient file at the rest home.
[14] Full of, containing, forming, or discharging pus.
[15] Used to treat moderate and moderately severe pain.
[16] RN D made similar notes in the wound care record.
[17] Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is any strain of *Staphylococcus aureus* that has developed, through the process of natural selection, resistance to beta-lactam antibiotics, which include the penicillins (methicillin, dicloxacillin, nafcillin, oxacillin, etc) and the cephalosporins.
[18] Antibiotics.
[19] An antibiotic containing sulfamethoxazole and trimethoprim.
[20] As referred to above, Mrs A was already on long term antibiotics for previous biliary sepsis.

"discussion usually occurred" regarding Mrs A's condition. RN D further advised HDC:

> "[Mrs A] herself appeared to be aware that the wound on her left leg was not healing as this matter was discussed with her at each change of the dressing."

70. Rest home Director RN J advised HDC:

> "[Mrs A] was kept up to date [by staff at the rest home] as a result of the swab. I do not know if they specifically told her she had MRSA or if it had just been commented on being an infection. I cannot comment on whether [Mrs B] was alerted formally."

71. There is no record of any conversations between staff at the rest home and either Mrs A or Mrs B regarding Mrs A's MRSA infection.

72. Wound care records dated 8, 9 and 10 Month2 noted a "[l]arge [and] offensive ooze" from Mrs A's graft site.

73. On 13 Month2, Mrs A had a follow-up appointment at the outpatient plastics clinic with Dr I. Dr I noted that there was a "superficial infection", that Mrs A was taking antibiotics, and that there was no further surgical treatment required at that stage. Dr I's records state: "[N]eeds debridement and ongoing dressings, probably every 2 days or so until the wound cleans and has a chance to heal. The donor site has also been slow to heal and will need ongoing dressings." Mrs A's progress report from the rest home states: "Returned early pm: Dressings to be Done Daily as per instructions from RN @ [the] DHB." RN D noted in the care plan: "Reviewed [the outpatient plastics clinic]. Instructions as per attached regime." A note attached to the care plan dated 13 Month2 states:

> "Daily Dressing to Graft site … if it is looking better after day 1, leave for 2 days … Donor site: = use xerofoam,[21] can be left for up to 4–5 days, reassess + repeat."

74. That is the last entry in Mrs A's care plan prior to Mrs A's transfer to hospital on 5 Month3 (see below).

75. On 14 Month2, it is recorded in the wound care record that Mrs A's graft site was redressed and that there was "very little exudate".[22]

15 Month2 — Mrs A's second fall at the rest home

76. On 15 Month2, Mrs A lost her balance and was found on the floor by a staff member. It was noted in Mrs A's progress report: "Incident form completed and Mrs B [n]otified." There is no record of any amendments to Mrs A's care plan.

16–30 Month2 — further deterioration in Mrs A's graft site

77. Staff rosters record that RN C was working on the floor on 16 and 18 Month2. On 16, 18, 20, and 22 Month2 it is noted in Mrs A's wound care record that Mrs A's graft

[21] A sterile fine mesh gauze used in wound dressing.
[22] Fluid that filters from the circulatory system into lesions or areas of inflammation.

site was redressed. On 22 Month2 it is recorded that there was a "purulent discharge" from the graft site.

78. On 24 Month2, Mrs A's graft site was again redressed. It is recorded in the progress report: "Copious green slough from area [left] leg. Area top [leg] thigh appears clean, slight bleed."

79. There were no changes made to Mrs A's care plan at that time. Furthermore, there are no further notes in the progress report regarding wound care or redressing for Mrs A until 4 Month3 (discussed below). However, the wound care record for 27 and 29 Month2 states that "purulent ooze continues", with a "slight improvement" noted on 29 Month2.

1–4 Month3 — stroke-like symptoms

80. On 1 Month3, Mr and Mrs B noticed that Mrs A was speaking as though the right side of her mouth was numb. Mrs B told HDC that she advised RN E, who said that she would note it down and get someone to contact the doctor the following day. Mrs B said that RN E told her that it appeared that Mrs A had had a stroke.

81. RN E told HDC that she has no recollection of this conversation. She said that she would not have made a diagnosis or commented that Mrs A had had a stroke, especially without having assessed her. RN E further stated that if such a conversation had taken place she would have assessed Mrs A and requested medical review. There is no record of any conversation between Mrs B and RN E on 1 Month3. Also, there is no record that rest home staff called a doctor to assess Mrs A on 1 or 2 Month3.

82. On 4 Month3, Mrs B found Mrs A in her room in a confused and distressed state, talking to herself. Mrs B told HDC that Mrs A was "sitting there talking about nothing [and] I couldn't make sense of anything. I tried talking to her and she didn't hear or understand me."

83. Mrs B stated that she asked a food service staff member, Ms G, how long Mrs A had been in a confused state. Ms G stated that Mrs A had been "like that all week". Mrs B told HDC that she wanted a registered nurse to review her mother, but Ms G told her that no registered nurses were on duty that day.

84. Ms G confirmed to HDC that she spoke to Mrs B regarding her mother's condition, but said that she did not advise Mrs B that no registered nurse was on duty that day. Ms G stated:

> "What I do recall saying to [Mrs B] was that [RN C], the facility manager was the Registered Nurse on, but she was in a meeting at the time of being asked. I relayed to [RN C] at the end of her meeting that [Mrs B] would like to see her."

85. RN C confirmed to HDC that on 4 Month3 she was rostered on as the registered nurse. She said that Mrs B had left by the time she finished her meeting, but that she reviewed Mrs A. RN C stated that she asked Mrs A if she was feeling ill, or had any concerns, to which Mrs A replied, "Not really." There is no record of RN C's assessment of Mrs A on 4 Month3.

86. RN C told HDC that "there was no apparent reason to call the doctor … however a fax was sent requesting a review of her leg and explaining [Mrs B's] concerns." Neither the rest home nor Dr H were able to provide HDC with evidence of a fax sent to Dr H at that time.

87. Dr H visited the rest home that afternoon but he did not review Mrs A, as her leg had just been dressed that day and he was scheduled to visit her two days later, on 6 Month3. RN E recorded in Mrs A's progress report: "Dressing to leg changed. [Dr H] will be in on [-day] to check please leave dressing until he arrives, mobilising [with] assistance."

88. The registered nurse communication diary states: "[Dr H] [called] had just finished her dressing coming back [-day]." There is no record of the condition of Mrs A's wounds at the time they were redressed.

89. Dr H told HDC that it was difficult to recall details of this visit, but he confirmed that he visited the rest home and recalls being told that Mrs A's leg had just been redressed. Dr H stated that he believes that this would have been an "informal visit, perhaps while … visiting other patients". He recalls that he did not review Mrs A's leg as he was scheduled to visit her in a few days' time.

Request for medical review

90. EN F told HDC that at approximately 10am on 5 Month3 she assessed Mrs A and found that she was confused and disorientated, had slurred speech, a visible right-sided drooping of her mouth, and right-sided weakness of her torso. EN F asked RN C to assess Mrs A. RN C said it appeared that Mrs A had had a stroke. RN C told HDC that directly after assessing Mrs A she sent a fax to Dr H requesting him to attend. Neither the rest home nor Dr H were able to provide HDC with a copy of a fax sent to Dr H at that time. The rest home advised HDC that its staff monitored Mrs A while they waited for Dr H, but this is not documented.

Transfer to Hospital

91. At 10.30am EN F telephoned Mrs B and told her that Mrs A was "in a bad way" and that Dr H had been contacted. EN F told Mrs B that staff would contact her as soon as Dr H had seen Mrs A. Mrs B stated that she asked that staff contact her on her cell phone if she was unable to be reached at home, but she did not receive a further telephone call from rest home staff.

92. At 12.30pm Dr H assessed Mrs A and recorded the following:

> "This morning her speech was slurred, [right] side of face was weak, and she couldn't get up. Now — speech reasonably good face fairly symmetrical but [right] arm very weak and some weakness [right] leg."

93. Mr and Mrs B told HDC that they arrived at the rest home after midday and were met at the door by EN F, who said that Dr H had assessed Mrs A. EN F advised Mrs B that Mrs A had had a major stroke. Mrs A was taken to the Hospital by the ambulance service, and Mr and Mrs B followed.

94. Mrs A's progress report states: "[Mrs B] aware. Transferred at 1330." However, there is no detail regarding what clinical staff told Mrs B, or what time she was contacted. Ambulance service records note that Mrs A had been "becoming ↑ [increasingly] confused last 3 days" and that Mrs A had had surgery on 2 Month1 for removal of a growth.

Hospital

95. Mrs A's resident transfer form signed by RN C states that Mrs A's normal state of health included eating and drinking independently, and that she had good hearing, sight and communication. It notes that Mrs A normally required some assistance with dressing, was "fully dependent" with regard to bathing or showering, and that Mrs A was "[u]sually very alert & lucid. Over last 3 days becoming more confused. This morning very confused, not orientated to time or place. Speech slurred & visible right drooping of mouth & [right] sided weakness … Skin graft [left] leg 1/2 Month1."[23]

96. On 5 Month3, the clinical notes from the Hospital record:

> "Daughter visited on [1 Month3] and thought speech sounded slurred, mumbling — describes like sound made after visiting dentist for tooth extraction …"

97. Mrs B told HDC that staff at the Hospital advised her that Mrs A had not had a stroke, as she was able to move her right side. The medical team concluded that Mrs A had overwhelming sepsis and pneumonia (not related to Mrs A's previous MRSA infection).[24]

98. On 12 Month3, after consultation with Mrs A's family, the medical team withdrew active treatment, and Mrs A died a short time later.

Subsequent events

99. As a result of HDC's investigation into the events regarding Mrs A, the rest home undertook a review of its processes and made the following changes:

Wound care

100. The rest home now uses the district health board's (DHB) wound chart, which requires photographs of wounds to be taken to record improvement or decline of wound healing. The chart addresses areas such as: wound dimensions, type of wound bed, wound exudate, and signs of infection.

101. The rest home has also updated its wound care policy. The new wound care policy specifies how to complete wound dressing. It states:

[23] Hospital clinical notes showed that Mrs A was no longer taking Deprim at the time of her admission to hospital.

[24] The laboratory report dated 5 Month3 from a swab taken from Mrs A's graft site states: "No Growth of [MRSA]." A further report regarding a swab also taken from Mrs A's graft site on the same day states: "Heavy Growth of PSEUDOMONAS AERUGINOSA." *Pseudomonas aeruginosa* is a common bacterium that can cause disease in humans. The symptoms of such infections are generalised inflammation and sepsis. If an infection occurs in critical body organs, such as the lungs, the urinary tract, or kidneys, it can be fatal.

> "… treatment is written in Care Plan, a photograph is taken of the wound with appropriate measurements taken, a wound sheet is commenced to ensure that all staff who are competent and responsible for treatments are dressing the wound the same way using the same technique and are signing for it. The fact that a new treatment is instigated will be noted on the assessment sheet and in the care plan.
>
> …
>
> an evaluation of the wound will be recorded in the care plan on a regular basis i.e. weekly or when changes are made or if wound deteriorates."

102. RN C said that she has worked with the local Health Centre to enable staff at the rest home to be able to access the district nurses for advice on wound care. She said that staff at the rest home are also now able to access the Community Wound Clinic, a new initiative by the DHB, which is run by a wound care specialist and a gerontology nurse specialist.

103. RN C advised that all registered nurses and enrolled nurses at the rest home have received independent training on wound care from Bug Control New Zealand Limited.[25]

Documentation

104. RN J told HDC:

> "I feel we really failed in this area quite badly, writing in diary pages is not good practice and … failing to document at all is not acceptable."

105. The rest home has now ensured that all registered nurses have a stamp with their name and registration number on it, in order to comply with its documentation policy. Each day the registered nurse in charge is to read all progress notes, then stamp them to indicate that they have been read. It is now standard practice that copies of all faxes are kept on patient files.

106. RN C advised HDC that she has instigated training in "Support of the Older Person — Level 3", and that she has supported all caregivers to receive the training. RN C advised that the training included a section on the importance of accurate documentation. She stated:

> "This education, I believe as the facility manager has resulted in a significant improvement in the resident's progress notes documentation. At our recent Ministry of Health Audit (January 2013), we received a full attainment in documentation, where previously in the 2011 audit, documentation only received a partial attainment.
>
> …

[25] Bug Control New Zealand Limited's website states that Bug Control is "the leading infection, prevention and control consultancy firm for primary care, residential and community care, and the out of hospital setting throughout Australia and New Zealand".

> I acknowledge that [Mrs A's short-term care plan] was not documented to a satisfactory standard … It is now policy to update care plans upon receiving a resident back into care. This is completed by using the Inter-Rai Assessment Tool (National Computerised tool based on a comprehensive geriatric assessment). This tool assists the registered nursing staff to provide an accurate and standardised assessment and denotes triggers of care that may require follow up.
>
> …
>
> It is also now policy that should staff require clarification on assessment or advice outside of office hours, I am on call 24/7 for staff to ring me. [RN D], Clinical Nurse Manager, takes on the on-call role should I not be available."

Communication

107. The rest home's policy with regard to communication now includes the following statement:

> "It is important for all conversations with visitors/family/EPOAs whether formal or informal to be documented on the communication sheet."

108. The rest home advised that all information regarding consumers' care is now communicated with their families, even if a relative has accompanied the consumer to relevant appointments. The rest home has reminded staff that all informal conversations are to be documented.

109. RN D advised that a six-monthly review of each resident is now sent to the resident's next of kin, with an invitation to discuss any queries he or she may have in regard to the family member. RN D advised that any queries are addressed by her.

110. RN C advised HDC that registered nurses and enrolled nurses at the rest home have attended a communication seminar through New Zealand Aged Care Association.

Staffing

111. The rest home advised HDC that it has hired two additional registered nurses at the rest home, and that the rest home is now "fully staffed with registered nurses [for] the first time in many years".

Response from the rest home

112. The rest home advised HDC that Mrs A did not show any signs of being unwell until 5 Month3, when Dr H was called "to what everyone thought were signs of a [cerebrovascular accident]". The rest home further stated: "We do take seriously the areas we have fallen short. We have learnt from this and have made changes to individuals' practice, procedures within the facility and in our company overall have been reported and altered to reflect best practice."

Response from RN C

113. RN C advised HDC that since becoming the facility manager at the rest home she has attended the Management Basics Training through the DHB. She attends the New Zealand Aged Care Association Conference annually, and is part of the local Rural

Nurses Forum, which she said is "an avenue for reflection on practice and upskill". She further stated:

> "I believe because of this complaint my practice has improved and made me more aware and reflective of my own practice. It has heightened my awareness to ensure I continue to up skill and keep abreast of changes in particular to clinical care changes. I now attend all relevant training sessions that I can to ensure I continue to build on my current knowledge base.
>
> …
>
> [F]urther to my verbal apology to [Mrs B] … I sincerely apologise for any part I played in the unfortunate circumstances that gave rise to this complaint both from an organisational and personal point of view."

Response from RN D

114. RN D advised HDC:

> "My current role is to ensure and oversee all short and long term care plans are commenced, updated as required or when any changes occur.
>
> …
>
> [T]his complaint has enabled me to reflect on my practice and look at strategies that enable me to ensure that I strive towards providing quality of care for all residents. Over the last year I have gained new knowledge and information by attending professional development.
>
> …
>
> I sincerely apologise for the role that I had in this complaint and regret any undue distress that it caused for [Mrs A's] family."

Opinion: The rest home

Introduction

115. In accordance with the Code, the rest home had a responsibility to operate in a manner that provided its clients with services of an appropriate standard. The New Zealand Health and Disability Sector Standards (NZHDSS) also require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers.[26]

116. With regard to the organisational responsibilities of rest homes, this Office has previously noted:

[26] New Zealand Health and Disability Sector (Core) Standards (NZS 8134.1.2:2008, Standard 2.2).

> "That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It also includes responsibility for the actions of its staff."[27]

117. I consider that the rest home failed in its organisational duty to ensure that Mrs A received services of an appropriate standard while at the rest home, for the reasons set out below.

Documentation — breach

118. The NZHDSS require that consumer information is "uniquely identifiable, accurately recorded, current, confidential, and accessible when required".[28] As noted in a previous Opinion, "this includes ensuring good clinical records are kept and documentation remains up to date. This is essential to providing good care of an appropriate standard."[29] The rest home's Documentation Policy valid at the time of these events required staff documentation to be objective and accurate.

119. I am of the view that Mrs A's care and treatment between Month1 and Month3 was inadequately documented. I accept that individual registered nurses are responsible for ensuring that their own documentation is comprehensive and accurate. However, I consider that there was no systematic approach to documentation at the rest home. As further outlined below, the documentation system that had developed at the rest home caused staff to have an incomplete picture of Mrs A's clinical condition. Furthermore, staff at the rest home consistently failed to document Mrs A's care and treatment adequately.

Documentation of wound care and clinical management

120. Information with regard to Mrs A's wound care and clinical management was recorded in four separate locations (care plan, progress report, wound care record, and a registered nurse communication diary). There does not appear to have been any system or reason for recording notes in one location rather than another. I agree with my expert advisor, RN Jan Grant, that having information in several areas leads to poor collation of critical information and, in the case of Mrs A, no comprehensive file in relation to her wound care. In my view, this impacted on the poor wound care provided to Mrs A (see below).

121. In my view, there is also inadequate documentation of Mrs A's condition in the clinical records. RN Grant advised that, following Mrs A's surgery on 2 Month1, she would have expected frequent and accurate progress notes to have been written, including more frequent entries in the progress report from the registered nurses. However, as noted by RN Grant, there were 21 days between 2 Month1 and 5 Month3 on which there were no entries made at all in the progress report, when the evidence available about Mrs A's condition at that time indicates that there should have been such entries. RN C made no record of her assessment of Mrs A on 4 Month3. In

[27] See Opinions 10HDC01286 (18 November 2013) and 12HDC07091 (13 June 2014), available at www.hdc.org.nz.
[28] NZS 8134.1:2008, Standard 2.9.
[29] See Opinion 11HDC00883 (11 June 2014), available at www.hdc.org.nz.

addition, on the two occasions when it was documented that Mrs A had suffered falls, her care plan was not amended with regard to her changing condition.

122. Furthermore, when notes were documented, they appear to have lacked the detail expected. In particular, RN Grant advised that the documentation with regard to Mrs A's wound care and clinical management lacked the detail that would be expected for a patient such as Mrs A. RN Grant noted that the content of the wound chart was limited to the amount of exudate and the type of dressing used, whereas "current practice in wound care is to accurately record a wound assessment at each change of dressing and understand the implications of each of the areas that are assessed". The level of documentation of Mrs A's wound care does not appear consistent with the rest home's wound care policy that applied at the time, which required "full documentation of any dressings applied to the wound … and changes to the short term care plan as appropriate", and which also stated that all care staff are responsible for appropriate documentation, analysis and prevention when assessing and dressing wounds.

123. I agree with RN Grant that the documentation failures in this case did not allow for an accurate review of Mrs A's care. With regard to documentation, RN J acknowledged that the rest home "really failed in this area quite badly".

Documentation of communication

124. At the time of these events, the rest home's "Communication with Families" policy required that a record be kept of all communication with a client's nominated contact person. Nevertheless, there is a notable lack of documentation of communication between rest home staff and Mrs A's family. There is also a notable lack of documentation of communication between rest home staff and Dr H.

125. With regard to communication with Mrs A's family, the rest home stated that communication occurred "most days"; however, there are only a few occasions on which communication with Mrs A's family has been documented. On those occasions notes are very brief (eg, on Month1 11 "[Mrs B] notified" and on 5 Month3 it was recorded in the progress report: "[Mrs B] aware. Transferred at 1330.") There is no record on any occasion of what was discussed with Mrs A's family about her clinical condition.

126. With regard to communication with Dr H, the rest home advised that there were two occasions, on 4 Month3 and 5 Month3, on which faxes were sent to Dr H regarding Mrs A's condition, but the rest home was unable to provide HDC with copies of the faxes.

127. RN C told HDC that on 4 Month3 she sent a fax to Dr H following an assessment of Mrs A, requesting that he attend the rest home to assess her. However, there is no evidence that a fax was sent to Dr H on 4 Month3, or that Dr H attended the rest home in response to a request from staff. Consequently, I find it more likely than not that no fax was sent to Dr H on 4 Month3.

128. RN C told HDC that on 5 Month3, following an assessment of Mrs A, she sent a fax to Dr H requesting that he assess Mrs A. As Dr H attended the rest home to review

Mrs A on the morning of 5 Month3, I am satisfied that RN C sent a fax to Dr H, but did not retain a copy on the client file.

129. It is unsatisfactory that the rest home did not ensure that information was recorded adequately and retained on Mrs A's file with regard to communication with her GP. As noted by RN Grant, such faxes are part of the picture of clinical care and treatment provided to a patient, and must be included in the clinical file of a patient. The rest home advised that it is now standard practice to keep copies of all faxes.

Conclusion

130. The rest home had the responsibility to operate in a manner that provided Mrs A with services of an appropriate standard. This included responsibility for the actions of its staff. In my view, staff consistently failed to document Mrs A's care and treatment adequately between 2 Month1 and 5 Month3. Furthermore, I consider that the rest home failed to ensure that it had adequate systems in place to guide clinical and care staff at the rest home with regard to documentation. In these respects, the rest home's documentation of Mrs A's care and treatment did not meet the NZHDSS and fell well below an acceptable standard. Accordingly, the rest home breached Right 4(2) of the Code.

Clinical care and treatment — breach

131. In my view, Mrs A was not provided with appropriate care and treatment at the rest home following her surgery on 2 Month1, particularly with regard to her wound care.

132. The Hospital discharge summary dated 2 Month1 gave clear instructions that Mrs A should be immobile, and should be admitted to the hospital wing of the rest home. My expert advisor, RN Grant, advised that the fact that the discharge letter from the Hospital recommended Mrs A have hospital-level care was a clear indication that Mrs A's needs had increased and that a higher level of care was required. Despite this, there is no evidence that Mrs A's needs were assessed, or that she received a higher level of care at the rest home following her surgery on 2 Month1. In particular:

- The rest home advised that when Mrs A arrived back at the rest home on 2 Month1, there were no beds available in the hospital wing of the rest home. Although the rest home did not have a hospital bed available at that time, I agree with my expert advisor that it should nevertheless have ensured that adequate staff were available to monitor Mrs A, and to provide the level of care that she required.

- The rest home's wound care policy relevant at the time of these incidents required that "[a]ll residents have individual care plans for all wounds, which are evaluated a minimum of 2 weeks or sooner as required". However, a new care plan was not commenced following Mrs A's surgery on 2 Month1.

133. RN Grant advised me that Mrs A's wound care instructions given on 2 Month1 following her surgery were clear. RN Grant stated that she would have expected that Mrs A's wound care and higher needs level would have been recorded in a new care plan, and the wound care record should have been commenced on that day. The failure to document a new care plan and wound management plan meant that Mrs A's

care plan did not communicate her increased needs to rest home staff effectively. As noted in a previous Opinion:

> "In order to provide good care in a rest home environment, residents' care plans must be well documented. A care plan is a fundamental tool that helps enable all staff to provide care that is appropriate and consistent with a resident's needs. It is a tool that informs staff of a resident's changing needs and where the care provided needs to be modified. It is the proper documentation of this process that ensures continuity of care."[30]

134. Furthermore, as noted by RN Grant, Mrs A's wound care lacked a systematic approach. I accept RN Grant's advice that there was no clear and accurate assessment of Mrs A's wounds at each dressing change, and her lack of progress and continued heavy exudate, particularly after 25 Month1, should have initiated a further medical review, either with Mrs A's GP or through a referral back to the Hospital.

135. There is also no evidence that nursing staff carried out a full assessment of Mrs A or took her baseline recordings (such as pulse, temperature, blood pressure or respirations) when she was noted to have deteriorated on 5 Month3.

136. I accept RN Grant's advice that rest home staff should have put in place a new care plan for Mrs A's wound care from 2 Month1. I also consider that the rest home should have ensured that its staff were adhering to the wound care policy. Rest home staff failed to implement the Hospital's recommendations for Mrs A's care properly, or to implement a new care plan and wound care management plan for Mrs A on her return from the Hospital.[31] Mrs A's wound care was also inadequate.

137. While I have identified my concerns about the actions of RN C and RN D in relation to these clinical failures (see below), the rest home had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code. In my view, it failed in that responsibility and breached Right 4(1) of the Code.

Communication with Mrs A or her primary contact person — adverse comment

MRSA infection

138. On 28 Month1, a swab was taken from Mrs A's graft site and sent to microbiology to check for infection. The results indicated an MRSA infection. RN J advised HDC:

> "[Mrs A] was kept up to date [by rest home staff] as a result of the swab. I do not know if they specifically told her she had MRSA or if it had just been commented on being an infection …"

[30] See Opinion 11HDC00883 (11 June 2014), available at: www.hdc.org.nz.

[31] RN Grant stated that the clinical notes indicated that there was a "heavy" or "purulent" ooze coming from Mrs A's wound from as early as 25 Month1, which did not resolve. RN Grant advised that "[t]his lack of progress and continued heavy exudate should have initiated a medical review with a GP or a referral back to [the] public hospital". I note that Dr H saw Mrs A on 25 Month1 and prescribed antibiotics on 7 Month2. Further, Mrs A was reviewed again on 13 Month2 by Dr I, who noted that there was a "superficial infection" but that she was currently receiving antibiotics.

139. However, there is no evidence that Mrs A was informed of the infection. Furthermore, Mrs B told HDC that she was not informed that Mrs A's wound was infected, and there is no documentation that suggests otherwise.

140. I have discussed the rest home's documentation regarding conversations with Mrs A and her family above. As there is no record that the presence of MRSA was discussed with either Mrs A or Mrs B, as her primary contact person, I find it more likely than not that such conversations did not occur. I consider the lack of communication with Mrs A with regard to her MRSA infection to be suboptimal.

Hospital admission

141. On the morning of 5 Month3, Mrs B advised HDC that EN F contacted her and advised her that Mrs A was "in a bad way". Mrs B requested that someone from the rest home contact her once Dr H had assessed Mrs A. Mrs B advised that she was not contacted again by staff at the rest home before arriving at the rest home shortly after midday. I consider that the communication by the rest home's staff with Mrs B, as Mrs A's primary contact person, was poor.

Opinion: RN C

142. As the facility manager, RN C had overall responsibility for managing the rest home. Her responsibilities included supervising all staff and ensuring that residents received care of a high standard, delivered in accordance with their individual care plans. In addition to the responsibilities set out in her job description, the Nursing Council of New Zealand (NCNZ) Competencies for Registered Nurses state that the standard expected of a registered nurse in management is to promote a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.[32]

143. In addition to her managerial responsibilities, RN C also advised that she "still like[s] to do some shifts on the floor". In providing care as a registered nurse, RN C was also required to comply with relevant professional standards (as outlined above).

144. There are a number of areas in which the care provided to Mrs A by staff at the rest home fell below an acceptable standard, and for which RN C, as facility manager, must accept some responsibility. As further discussed below, those areas included clinical care and treatment, and documentation. There are also instances when the clinical care provided by RN C directly to Mrs A fell below accepted standards.

Clinical care and treatment — breach

145. The rest home's wound care policy relevant at the time of these incidents stated: "All residents have individual care plans for all wounds, which are evaluated a minimum of 2 weeks or sooner as required." Further, the rest home's wound care policy

[32] NCNZ "Competencies for Registered Nurses" (December 2007) competencies for nurses involved in management.

required staff to undertake "[o]ngoing analysis of … the resident's physical environment and health status to prevent further skin tears and skin breakdown".

146. With regard to Mrs A's wound care, I repeat paragraphs 131 and 132 above. There is no evidence that RN C took steps to ensure that individual staff updated or amended Mrs A's care plan when her condition changed, for example, when she suffered a fall, or following deterioration of her graft site from 16 Month2.

147. RN C failed to recognise that an appropriate care plan was not implemented or updated for Mrs A, or to ensure a systematic approach to her wound care. I acknowledge that RN C was not always working on the floor when she was on shift at the rest home. However, as facility manager, RN C had the overall responsibility for ensuring a quality service was provided to residents at the rest home. In my view, the failure of staff at the rest home to provide adequate care and treatment to Mrs A demonstrates a lack of leadership and/or oversight by RN C.

148. Furthermore, RN C's individual clinical care and treatment of Mrs A was not always adequate. On 4 Month3, Mrs B reported that Mrs A was in a confused and distressed state and was talking to herself. Ms G told Mrs B that Mrs A had been in that condition "all week".

149. Following a request from Ms G, RN C reviewed Mrs A. RN C advised HDC that following her assessment of Mrs A on 4 Month3, there was "no apparent reason to call the doctor …". However, RN C also told HDC that she sent a fax to Dr H requesting review of Mrs A's leg. RN C failed to make any notes detailing her assessment of Mrs A, and there is no record of a fax to Dr H.

150. Dr H recalls visiting the rest home on 4 Month3 and being told that Mrs A's leg had just been redressed. He believes that this would have been an "informal visit — perhaps while … visiting other patients". He recalls that he did not review Mrs A's leg, as he was scheduled to visit her in a few days' time.

151. There is no evidence that Dr H attended the rest home in response to a request for review by staff. RN C herself told HDC that there was "no reason to call [Dr H]". Consequently, I find it more likely than not that no fax was sent to Dr H on 4 Month3.

152. Furthermore, on 5 Month3 RN C signed a note in Mrs A's resident transfer form from the rest home to the Hospital stating: "… Over last 3 days becoming more confused …" Ambulance records dated 5 Month3 confirm that Mrs A had been becoming increasingly confused over the last three days.

153. In light of this, and in the absence of any documentation of RN C's assessment of Mrs A on 4 Month3, I find it more likely than not that on 4 Month3 Mrs A was exhibiting signs of deterioration, such as confusion and slurred speech, that should have alerted RN C to the need to seek immediate medical review. The relevant wound care policy stated that referrals to a GP or wound care specialist "should be made as required", which was not done. Overall, I consider that on 4 Month3 RN C failed to undertake an adequate assessment of Mrs A, or to organise a medical review in a timely manner.

154. Furthermore, there is no evidence that RN C carried out a full assessment of Mrs A or took her baseline recordings, such as pulse, temperature, blood pressure or respirations, when Mrs A was noted to have deteriorated on 5 Month3.

155. In my view, in respect of the clinical care and treatment failures set out above, RN C failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

Documentation — breach

156. As already outlined, the rest home failed to ensure that it had adequate systems in place to guide clinical and care staff at the rest home with regard to documentation, and staff consistently failed to document Mrs A's care and treatment adequately between 2 Month1 and 5 Month3 (see paragraphs 119 to 127 above). In my view, there was insufficient oversight of staff compliance with documentation standards at the rest home and, as facility manager, RN C must take some responsibility for that.

157. Furthermore, RN C personally failed to comply with professional standards with regard to documentation. RN C failed to make any documentation detailing her assessment of Mrs A on 4 Month3 2012. Furthermore, RN C told HDC that on 5 Month3 following an assessment of Mrs A, she sent a fax to Dr H requesting that he assess Mrs A. Shortly afterwards, Dr H attended the rest home to assess Mrs A. I am satisfied that the fax was sent by RN C to Dr H, but was not retained on the client file.

158. The Nursing Council of New Zealand "Competencies for registered nurses"[33] provides that nurses must adhere to the following competencies:

> "*Competency 2.2*
> Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings. …
>
> *Competency 2.3*
> Ensures documentation is accurate and maintains confidentiality of information.
>
> **Indicator:**
> Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework. …
>
> *Competency 4.1*
> Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care. …"
>
> **Indicator:**
> Maintains and documents information necessary for continuity of care and recovery."

159. I consider that RN C did not comply with professional standards in respect of her documentation. I consider the standard of documentation by RN C to be unacceptable,

[33] This document was first published by the Nursing Council of New Zealand in December 2007. It can be found at www.nursingcouncil.org.nz.

especially given her role as facility manager. In addition, in light of her role as facility manager, RN C had a responsibility to ensure that staff at the rest home complied with policy and professional standards with regard to documentation. RN C should have identified that standards were not being met by staff, and should have taken steps to improve the quality of documentation at the rest home. In my view, for these failures, RN C breached Right 4(2) of the Code.

Communication with Mrs A's primary contact person — adverse comment

160. As outlined in the facility manager's job description, RN C was responsible for liaising with relatives and "giving support and comfort where appropriate".

161. Mrs B told HDC that on the morning of 5 Month3, while RN C was on duty, rest home staff did not communicate adequately regarding the urgency of Mrs A's condition. The progress report records: "[Mrs B] aware. Transferred at 1330." However, there is no detail regarding what staff told Mrs B. Due to the absence of comprehensive documentation regarding communication between rest home staff and Mrs B on 5 Month3, I consider that adequate communication did not occur.

Opinion: RN D

162. As the clinical manager, RN D had overall responsibility for the clinical care provided to residents at the rest home. As part of her role, RN D was required to supervise registered nurses and caregivers and ensure that safe and professional nursing care was delivered. RN D's job description also stated that her responsibilities included:

> "Where possible residents and their families are involved in planning care and decision making related to nursing care.
>
> Care is carried out according to medical orders and nursing care plan.
>
> Standards for nursing practice are met.
>
> …
>
> To maintain documentation of resident care and health status.
>
> Each resident has a documented nursing assessment and nursing care plan.
>
> Nursing Care Plans are evaluated and updated at least every three months and as necessary.
>
> Nursing progress notes are written at least twice weekly and when necessary for each Resident …"

163. In addition to the responsibilities set out in her job description, the Nursing Council of New Zealand (NCNZ) Competencies for Registered Nurses state that the standard expected of a registered nurse in management is to promote a quality practice

environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.[34]

164. In providing care as a registered nurse, RN D was also required to comply with relevant professional standards (outlined above).

165. There are a number of areas in which the care provided to Mrs A by staff at the rest home fell below an expected standard, and for which RN D, as clinical manager, must accept some responsibility. As further discussed below, those areas include clinical care and treatment, and documentation. There are also instances when the care that RN D directly provided to Mrs A fell below accepted standards.

Clinical care and treatment — breach

Planning and implementation of care plans

166. As clinical manager, RN D had overall responsibility for ensuring that robust care plans were prepared and implemented by care staff. RN D failed to ensure that a wound care plan was implemented from 2 Month1 or that Mrs A's care plan was updated to reflect her increasing needs. I refer specifically to the following:

- The rest home's wound care policy relevant at the time of these incidents stated: "All residents have individual care plans for all wounds, which are evaluated a minimum of 2 weeks *or sooner as required*" (my emphasis). There is no record of a wound care plan on 2 Month1. My expert advisor, RN Grant, advised that she would have expected a new care plan and wound care management plan to be documented on 2 Month1 when Mrs A was transferred back to the rest home after her surgery.

  I acknowledge that RN D was not working on 2 Month1, and that she updated Mrs A's care plan on 3 Month1 when she returned to work following Mrs A's surgery. However, there is no evidence that RN D took steps to ensure that individual staff updated or amended Mrs A's care plan when her condition changed, for example, as soon as possible following her surgery, or when she suffered a fall.

- Further, the rest home's wound care policy required staff to undertake "[o]ngoing analysis of … the resident's physical environment and health status to prevent further skin tears and skin breakdown". As noted in paragraph 132 above, Mrs A's wound care lacked a systematic approach.

- Rest home staff failed to implement the wound care recommendations that the Hospital provided to staff at the rest home, including providing hospital-level care.

167. The rest home advised HDC that on Mrs A's return to the rest home, clinical staff were unable to adhere to the recommendation in the Hospital discharge form to admit Mrs A into hospital-level care, as there were no beds available in the hospital wing at the rest home. As discussed above, my expert advised that the rest home should have ensured that adequate staff were available to monitor Mrs A, and to provide hospital-

[34] NCNZ "Competencies for Registered Nurses" (December 2007) competencies for nurses involved in management.

level care. As there were no beds available in the hospital wing, consideration should have been given to employing extra staff to ensure that Mrs A received a higher level of care.

168. As the clinical manager, RN D had a responsibility either to make sure that there were adequate staff available to ensure that hospital-level care could be provided to Mrs A in accordance with the Hospital's recommendation, or to escalate the issue to the facility manager, RN C. RN D did not do either of these things. However, I note that RN D ensured that a hospital bed was made available to Mrs A on 3 Month1, which was appropriate.

169. RN D failed to ensure that care plans were initiated and implemented by care staff, or that staff implemented the recommendations in the Hospital discharge form. RN D also failed to ensure adequate clinical care of Mrs A's wounds. Accordingly, RN D breached Right 4(1) of the Code.

Documentation — breach

170. As already outlined, the rest home failed to ensure that it had adequate systems in place to guide clinical and care staff with regard to documentation, and staff consistently failed to document Mrs A's care and treatment adequately between 2 Month1 and 5 Month3 (see paragraphs 119 to 127 above). In my view, there was insufficient oversight of staff compliance with documentation standards and, as clinical manager, RN D must take some responsibility for that.

171. Furthermore, as a registered nurse, RN D was herself required to maintain "clear, concise, timely, accurate, and current records" according to relevant professional standards.[35] I acknowledge that RN D updated Mrs A's records regularly. However, I consider that the standard of documentation shown by RN D was not always adequate. For example, RN D documented and signed a note in Mrs A's care plan dated 2 Month1, but told HDC that she did not work on 2 Month1 and completed the documentation when she arrived at the rest home the following morning. RN D advised that she did so as she noted that a care plan had not been initiated the previous day, and in order to allow for sequential documentation.

172. I accept RN D's advice that she did not work at the rest home on 2 Month1, and that she completed the documentation dated 2 Month1 when she came on shift on the morning of 3 Month1. While I appreciate that RN D recognised that a care plan had not been initiated for Mrs A, she should have made it clear that her note was being made retrospectively.

173. As the clinical manager, RN D had a responsibility to ensure that staff complied with policy and professional standards with regard to documentation. In my view, the documentation failures in this case demonstrate that there was a lack of clinical leadership or oversight by RN D. RN D should have identified that standards were not being met, and should have taken steps to improve the quality of documentation at the rest home. Furthermore, I consider that RN D's individual standard of documentation was not always adequate. Accordingly, RN D breached Right 4(2) of the Code.

[35] Competency 2.3, Competencies for registered nurses.

Communication with Mrs A or her primary contact person — adverse comment

174. According to RN D's job description, she was responsible "where possible" for ensuring that "residents and their families are involved in planning care and decision making related to nursing care". I consider that the standard of communication between RN D and Mrs A or her primary contact person, Mrs B, was not always adequate.

175. On 28 Month1, RN D recorded in Mrs A's care plan that a swab was taken from her graft site to check for infection. The swab results indicated an MRSA infection. There is no record that Mrs A or Mrs B were informed of Mrs A's deteriorating condition with regard to the presence of infection. RN D advised HDC:

> "[Mrs A] herself appeared to be aware that the wound on her left leg was not healing as this matter was discussed with her at each change of the dressing."

176. However, there is no record of any such conversations with Mrs A, or that she was informed regarding the result of her swab. Further, Mrs B told HDC that she was not informed by staff at the rest home about Mrs A's infection. As there is no record that the presence of MRSA was discussed with either Mrs A or Mrs B as her primary contact person, I find it more likely than not that such discussions did not occur. Accordingly, I consider that the communication with Mrs A regarding her MRSA infection was suboptimal.

Opinion: RN E

Instigation of care plan — adverse comment

177. On 2 Month1, on her return to the rest home, Mrs A was assisted by RN E. There are no records that RN E instigated a wound care plan for Mrs A at that time. The rest home's wound care policy stated: "All residents have individual care plans for all wounds, which are evaluated a minimum of 2 weeks or sooner as required." My expert advisor, RN Grant, said that she would have expected a new care plan and wound care management plan to be documented on 2 Month1, when Mrs A was transferred back to the rest home after her surgery. I agree with my expert's advice, and am disappointed that a care plan was not implemented for Mrs A on her return to the rest home.

Communication with Mrs B — other comment

178. Mrs B advised HDC that on 1 Month3 RN E told her that it sounded as though Mrs A had had a stroke. There is no record of this conversation, and RN E denies making such a statement. RN E told HDC that she would not make a diagnosis regarding a stroke, especially without having assessed Mrs A.

179. Where there are conflicting accounts of relevant facts in the course of an investigation, it can be difficult to establish exactly what occurred. I am unable to make a finding as to whether this conversation with RN E occurred. However, I would be concerned if a clinician, on the basis of verbal information, considered that a

patient in his or her care may have had a stroke, and failed to follow up on the information by conducting a thorough assessment of the patient.

Recommendations

180. I recommend that the rest home undertake the following:

a) Provide evidence that its documentation system has been consolidated (in order to ensure improved communication amongst staff), and report to HDC **within three months** of the date of this opinion regarding its implementation.

b) Conduct an audit at the rest home to assess compliance with professional standards regarding documentation within **six months** of the consolidation of its documentation system, and report to HDC on the outcome of that audit. I recommend that both RN C and RN D be involved in the implementation of this audit and provide input into the report to HDC regarding the results of the audit.

c) Provide training to staff about the importance of having a comprehensive and up-to-date record of a resident's care and needs, and provide evidence of that training to HDC **within three months** of the date this opinion.

d) Provide a written and signed apology to Mrs A's family for its breaches of the Code. The apology is to be sent to HDC **within one month** of the date of this opinion, for forwarding.

181. I recommend that RN C provide a written and signed apology to Mrs A's family for her breaches of the Code. The apology is to be sent to HDC within **one month** of the date of this opinion, for forwarding.

182. I recommend that RN D provide a written and signed apology to Mrs A's family for her breaches of the Code. The apology is to be sent to HDC within **one month** of the date of this opinion, for forwarding.

Follow-up actions

183. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to HealthCERT (Ministry of Health) and it will be advised of the name of the rest home.

184. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C and RN D's names.

185. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board and it will be advised of RN C and RN D's names and the name of the rest home.

186. A copy of the this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Ms Jan Grant:

"Clinical Advice

Consumer: [Mrs A] (dec)

Provider: [Rest home]

File Number: C12HDC01286

Date: l0 February 20l3

I have no personal or professional conflict of interest in the case.

I have been asked to provide clinical advice in relation to the care provided to [Mrs A] while she was a patient at [the rest home]. [Mrs A] had surgery to remove a squamous cell carcinoma from her left lower leg with a split skin graft repair on the 2nd of [Month1]. The surgery was undertaken at [Hospital]. [Mrs A] was a day stay patient and following the surgery returned to [the rest home]. A discharge summary was provided to staff outlining cares required following surgery. These cares included

1. Complete bed rest

2. Complete course of antibiotics

3. Elevate left leg. Strict bed rest 5/7 up to toilet l–2 x day only

4. Contact GP if any concern

5. Advise staying in hospital wing of rest home as unable to mobilize for 5/7

6. Do not disturb donor site

7. Reinforce with tegaderm if leakage

8. If tegaderm becomes over filled ooze this can be aspirated and resealed.

The progress notes of the 2 [Month1] stated that [Mrs A] returned and those instructions were listed.

The progress notes were documented in by caregivers, enrolled nurses and registered nurses. The entries were documented and signed. There were twenty one days from the 2 of [Month1] through till the 5 of [Month3] where no entries were made in the progress notes.

The following dates are when no documentation was listed in the progress notes.

[Month1] — 9th, 10th, 16th, 18th, 27th, 30th and the 3lst

[Month2] — 3rd, 5th, 10th, 14th, 17th, 22nd, 25th, 26th, 27th, 28th and the 29th

[Month3] — 1st, 2nd and 3rd

The discharge letter recommended that [Mrs A] was placed in a hospital level care bed to ensure that she received a higher level of nursing care. This should have alerted staff that her needs had increased and that if the facility did not have a

hospital bed then extra staff may have been required to have been employed to ensure she received that higher level of care.

Taking into account her wound and her higher needs level I would have expected that she would have had a new care plan documented (one was not presented with the documentation) and that frequent accurate progress notes would have been written.

There were a number of days where no entries were documented and the progress notes and wound chart indicated that there should have been entries

e.g. [Mrs A] was reviewed at [the public hospital] on the 8th [Month1]. Her clinical notes stated

'To [the outpatient plastics clinic] for ROC clips from graft cleaned betadine and redressed with jelonet gauze and hyperflix, Tubigrip for protection. To be dressed in 3 days — [day]. Donor site — this is to be removed in 3–4 days. Leg is to be kept elevated as much as possible please'

This entry was very clear as to care needed including wound care. There was nothing in the progress notes until the 11 [Month1] at 13.50hrs and this entry stated

'No shower up to having shower this morning 11.50am [Mrs A] fell to floor getting up from chair hoist back to bed had no lunch BP 110/70 nil injuries sustained [Mrs B] notified'

This entry did not document wound care.

The first date on the wound care record is the 14th of [Month1].

It is my opinion that the progress notes lacked the detail that would be expected in a patient such as [Mrs A]. She had high needs, being unable to weight bear and with her wound care needs, I would have expected a registered nurse to check the progress notes and document that they had done so. I would also have expected more frequent entries in the progress notes from the registered nurses. A short term care plan would be the expected norm for a resident who had had such interventions (one was not presented in the documentation). Failure to document did not allow an accurate review of her cares.

I am of the opinion that my peers would view this as a moderate departure from acceptable standards.

Wound Care

The wound care record is a two page document with the front sheet that outlines the position and type of the wound. The bottom half of the sheet indicates the initial dressing used. There is a space for a review of the wound by the wound coordinator and the dressings applied. The first entry on the wound chart is the 14th of [Month1].

The evaluation date for the wound is the 17th of [Month1]. No other evaluations were documented on this part of the wound chart. The second part of the wound record is an evaluation and dressing progress notes. These were documented on the following dates —

[Month1] 16th, 22rd, 23rd, 25th, 28th and 30th

[Month2] lst, 3rd, 4th, 5th, 8th, 9th, 10th, 14th, 16th, 20th, 22nd, 24th, 27th and 29th

[Month3] lst, and 4th.

The documentation related to the wound evaluation. The content of the entries varied from

'opsite to donor site cut/c gauze pack and gamgee, bandaged'

'*mod purulent ooze from graft site surrounding are inflamed cuticerin gauze and ganigee'*

'*large offensive ooze solosite honey and packed gamgee and bandage'*

'*Redressed by [EN F]'*

'*donor site redressed as per villa 4 leg wound cleaned, cuticerin applied gauze melolin and hyperfix'*

'*Dressing to donor site L) lower leg redone copious green slough from L.) lower leg'*

Generally the content of the wound chart was limited. It described the amount of exudate and what dressing was used to cover the wounds.

The current practice in wound care is to accurately record a wound assessment at each change of dressing and understand the implications of each of the areas that are assessed. Many facilities use a generic wound chart which would have the following headings on which to assess.

An example would be:

Location of wound and size of the wound (photos are commonly used)

• Predominant Tissue Appearance, The percentage amount of tissue eg Granulation, slough, eschar, infection

• Odour e.g. nil, offensive, product odour

• Exudate e.g. quantity, type

• Surrounding skin e.g. normal, cellulitic, discoloured, eczematous, erythema macerated, oedematous.

• Other e.g. exposed bone, tendon, sinus, fistula, dehiscence

• Aim of treatment e.g. debride, absorb, promote granulation. hydrate, protect

• Dressing chosen and frequency of dressing

Other areas that should be included are pain, swabs taken etc.

Using a format allows each dressing change and assessment to be accurately recorded; it also ensures consistency from each health professional. It is much easier to see deterioration in a wound.

[Mrs A's] wound instructions were clear. Instructions were given on the 2nd of [Month1] following her surgery. The wound care record should have been commenced on that day.

On the 10th of [Month1] she was in [the outpatient plastics clinic]. At that stage the progress notes from [the] Hospital stated that there were no obvious signs of infection. It also stated what the graft site should be cleaned with and that it should be reviewed in three days. The donor site was also to be reviewed in 3–4 days.

On the 22nd of [Month1] [RN C] Facility Manager stated that she rang the district nurses to ensure that they were on the right track re the graft site. She stated in her response … that the facility was using the correct dressing for the wound.

The progress notes stated that a swab should be sent to the lab if staff thought the wound was infected. The wound care record was signed but the designation was not noted. Was each dressing change undertaken by a registered nurse? It would be accepted practice for a registered nurse to have completed all wound dressing changes.

The progress notes stated that the wound was seen by [Dr H], a swab was to be sent to the lab on [-day]. The notes did not state if a swab was sent. There was a swab result dated the 28th of [Month1] which showed that MRSA was present in the wound, (these notes are from [the Hospital]). The medical notes stated that [Dr H] did a three monthly review but the notes stated that '*Large wound — dressing — review in a few weeks'*

The progress notes indicated that the wound had heavy purulent ooze.

It is my opinion that the wound management lacked a systematic approach. Progress notes indicated that there was a heavy purulent ooze from the wounds from the 25th of [Month1]. This is certainly documented in the evaluation and dressing record. This lack of progress and continued heavy exudate should have initiated a medical review with a GP and of a referral back to the public hospital. As documented previously it is important to have a clear and accurate assessment at each change of dressing. I do not believe this happened consistently. The outcome for [Mrs A] may not have been any different but accurate on-going documentation would have shown appropriate nursing actions.

I am of the opinion that my peers would view this as a moderate departure from acceptable standards.

Communication with Family

[Mrs A's] daughter stated that she visited her mother on the 1st of [Month3] and the right side of her mouth was numb. Her daughter passed this information on to the registered nurse on duty. Nothing was documented in the progress notes of this discussion. There were no entries in the progress notes from the 30th of [Month2] till the 4th of [Month3]. [Mrs A's] daughter visited again on the 4th of [Month3] and stated that she found her mother to be very confused. On questioning the staff; they implied that she had been like this all week. No evidence of any documentation for this. On the 5th of [Month3] her daughter received a call from [EN F] to say that [Mrs A] was in a bad way. The family visited in the afternoon and were advised that [Mrs A] had had a major stroke. [Mrs A] was admitted to the public hospital that afternoon.

The progress notes of the 5th of [Month3] stated

09.30 'speech slurred evident R sided weakness and drooping of mouth Unable to weightbear. Hoist required for transfer'.

1300 'S/B [Dr H] for transfer to [the] Hospital/for ? CVA [Mrs B] aware transferred at 1330hrs'.

The notes did not give any record of any registered nurse assessment. No base line recordings were taken. There was no documented discussions and communication with family.

I am of the opinion that the communication with family was poor. There was no evidence as to any discussions that may have taken place. I believe my peers would view this as a mild departure from acceptable standards.

Summary

From the information I have viewed I am of the opinion that [Mrs A] did not receive an adequate standard of care. The progress notes were lacking in detail and there were many days where no entries were listed. There does not appear to have been a thorough nursing assessment and documented short term care plan. The wound care chart although completed at each change of dressing was also lacking detail in relation to accurate assessment. Communication with the family was not documented. It did not appear that the family was kept up to date on the deterioration in [Mrs A's] condition.

Jan Grant

14 February 2013"

The following further advice was received from Ms Grant on 24 November 2013:

"I have been asked to provide further advice following additional information from [the rest home] and staff employed there.

My initial advice outlines my opinion in relation to wound care. I have not changed my opinion following further statements from staff.

I am of the opinion that as [Mrs A] was a patient/resident at [the rest home] then this facility was responsible for the following:

> wound care

> outside support such as district nurses

> specialists at the DHB that are used as a resource and advice can be sought if required.

When a patient/resident returns from a surgical procedure a wound chart should have been commenced I do not agree with the following statement that:

'the first day of wound care documented by [the rest home] was 14 [Month1] 2012, as this is the first day that staff at [the rest home] did the dressing. Up until this date it was done at [the] DHB. We had not seen the wound to commence a wound chart.'

A wound chart should have been commenced on the day the patient/resident returned. Although the instructions for wound care were documented in the Progress Notes they also should have been included in the Wound Care record. This allows for a clear, one entry documentation of the wound and progress etc.

I also do not agree with the following statement that:

'The evaluations were done each time a dressing was completed'

The evaluations and dressings recorded as stated in my previous advice only listed the amount of exudate and what dressings were used to cover the wounds.

[The rest home] has presented their new Wound Chart which is now used. This certainly would have shown an accurate and thorough assessment of the wound. The new chart includes areas such as:

- Wound dimensions
- Type of wound bed
- Wound exudate
- Pen wound
- Signs of infection
- Requirement for dressing used.

The use of a tool such as this, in my opinion would have alerted both medical and nursing staff that the wound was deteriorating.

The new wound care policy is more thorough. It clearly outlines how to complete a dressing. It outlines the wound healing process and the stages of wound healing. It also lists some of the wound products used. It is my opinion that used in conjunction with the Wound Management chart, wound management at [the rest home] will be of an adequate standard and well documented.

The nursing Progress Notes indicated that the wound had MRSA from a swab taken on the 28 [Month1]. The ward notebook indicated that the results of the swab were known on the 2 [Month2]. Antibiotics were not commenced till approximately the 7 [Month2].

It is my opinion that having information in several areas such as a wound diary led to poor collation of critical information and no comprehensive file in relation to [Mrs A's] wound.

[The rest home] [has] in my opinion acknowledged that there was poor communication between [Mrs A's] family in relation to her wound deterioration and general health. I have reviewed the new communication policy and in my opinion if this is adhered to the issues around lack of communication will be addressed.

Summary

Following reading the information [the rest home] sent I am still of the opinion that [Mrs A's] care would be viewed as a moderate departure from acceptable standards by my peers.

Jan Grant"

The following further advice was received from Ms Grant on 14 March 2014:

"I have been asked to provide further advice to the following three questions

On 4 [Month3] [Mrs B] found [Mrs A] in her room in a confused and distressed state, talking to herself.

[RN C] assessed [Mrs A]. She stated that on viewing [Mrs A], 'there was no apparent reason to call the doctor … however a fax was sent requesting a review of her leg and explaining [Mrs B's] concerns.' This fax has been destroyed. There is no record of [RN C's] assessment of [Mrs A] on 4 [Month3].

Clinical notes on the 4 [Month3] stated 'Dressing to leg changed [Dr H] will be in on [-day] to check please leave dressing until he arrives, mobilising with assistance'

The Wound Care record on the 4 [Month3] stated 'Dressing changed same regime as above'

Both of these entries were signed by [RN E], her designation is as Registered Nurse as she has signed RN.

There was no documentation from [RN C] in the Clinical Notes. [RN C] had a responsibility to document care and treatment provided to [Mrs A].

[RN C] advised that [Dr H] phoned [the rest home] that afternoon, however as her leg had only recently been dressed he decided to visit her two days later on 6 [Month3] to redress her leg.

The Clinical Notes were unclear as to if [RN C] visually sighted the wound. It would be good clinical practice if she had, as she had the overall responsibility to plan clinical decisions, treatments and assessment. Again nothing was documented by [RN C].

At approximately 10am on 5 [Month3] [RN C] assessed [Mrs A]. [RN C] advised HDC that on assessing [Mrs A] it appeared that she had had a stroke. [RN C] stated that [Mrs A's] 'speech was slurred, she was unable to move her right arm or leg and had evident facial drooping'. Staff sent a fax to [Dr H] requesting him to attend to [Mrs A]. [The rest home] did not keep a copy of this fax. [Dr H] attended [Mrs A] approximately 2 hours later.

Can you please provide your comment regarding the adequacy of [RN C's] actions in light of [Mrs A's] presentation, including sending faxes to [Dr H] on both the 4th and 5th of [Month3].

Faxes that are sent which relate to any clinical requirements or request for advice about a patient must be kept. This must be included in the Clinical File of a patient as they become part of the picture of care and treatment the patient received. Staff must be able to review the advice or request that was sought. It is certainly not common practice to destroy such correspondence.

Again the Progress Notes of [Mrs A's] stated

5 [Month3] '09.30 Speech slurred evident R sided weakness and drooping of mouth. Unable to weight bear Hoist required for transfers'

13.00 'S/B [Dr H] — for transfer to [the] hospital for ? CVA [Mrs B] aware transferred at 13.30 hrs'

The notes were signed by an EN.

As in my other evidence I am of the opinion these notes lack detail in both clinical assessment and on-going monitoring. No base line recordings were taken such as pulse, temperature, blood pressure, respirations. The fact that [Mrs A] was found with the clinical picture that is stated and that the staff hoisted her out of bed is very questionable. Patients who are frail and do not present a stable clinical picture should not be transferred or attempted to walk but rather be cared for appropriately in bed until senior clinical staff/doctors can assess.

[Mrs A] was very sick as indicated when she was admitted to public hospital. The Clinical Notes showed that there was limited assessment and poor judgement in [Mrs A's] care decisions.

I am of the same opinion as documented in February 13 that [Mrs A] did not receive an adequate standard of care.

Jan Grant"