Rest Home

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC02274)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman at a rest home in the last two weeks of her life — in particular, the assessment of her delirium, and the lack of escalation and critical thinking, including pain management, once she began to deteriorate.

2. The report highlights the importance of critical thinking in a rest-home setting, including nursing staff assessing symptoms overall (rather than assessing them in isolation), and recognising their cumulative impact as being indicative of a more significant problem warranting further intervention.

Findings

3. The Deputy Commissioner found that the rest home did not provide services to the woman with reasonable care and skill by failing to recognise and assess her sudden onset of delirium; failing to commence a food and fluid chart or monitor her input/output; failing to institute alternative pain-relief measures and appropriate pain management; and failing to institute an Advanced Care Plan, which meant that the woman's wishes for her end-of-life care were not taken into account. Accordingly, the Deputy Commissioner found the rest home in breach of Right 4(1) of the Code.

4. The Deputy Commissioner criticised the rest home's lack of documentation of the woman's wound infection, and reminded the rest home of the importance of updating care plans when situations change. The Deputy Commissioner was also mildly critical of the rest home's decision not to change the woman's dressings prior to transfer to the public hospital.

Recommendations

5. The Deputy Commissioner recommended that the rest home provide an update on the implementation of an electronic health record system; conduct an audit of patient records for staff compliance with rest-home policies; provide evidence of training provided to staff on relevant topics; schedule refresher education, and regular and ongoing education sessions every two years, for all nursing staff on topics including delirium and sepsis, escalation of care, advanced care plans, documentation, and hydration; and provide an apology to the woman's family for its breach of the Code.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint on behalf of the family of the late Mrs A, raising concerns about the services provided by a rest home. The following issue was identified for investigation:

- *Whether the rest home provided Mrs A with an appropriate standard of care in 2019.*

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

8. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's daughter
Mr C	Enduring Power of Attorney holder
Rest home	Provider

9. Further information was received from:

District health board (DHB)	
Dr D	General practitioner (GP)
Registered Nurse (RN) E	DHB wound care nurse practitioner
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse
RN J	Registered nurse
Physiotherapist	
Aged residential care liaison nurse	
Nurse practitioner	

10. Also mentioned in this report:

Ms K	General Manager
RN L	Registered nurse
RN M	Registered nurse

11. Independent expert advice was obtained from an aged-care nursing advisor, Ms Rachel Parmee (Appendix A).

Information gathered during investigation

Background

12. Mrs A, aged in her nineties at the time of events, was admitted to a rest home in 2019.

13. Mrs A had multiple co-morbidities including bilateral lower leg ulcers, chronic renal failure,[1] congestive cardiac failure,[2] ischaemic heart disease,[3] severe osteoarthritis on both hips,[4] and peripheral vascular disease.[5] Mrs A's daughter, Mrs B, was closely involved in her care. Mr C, Mrs A's grandson, held an Enduring Power of Attorney (EPOA)[6] for Mrs A's personal care and welfare. The EPOA was not activated as Mrs A still had capacity to make decisions for herself.

14. On 31 Month5,[7] Mrs A developed delirium and deteriorated. On 2 Month6, she was transferred to a public hospital via ambulance. However, she died at 4.15am on 3 Month6, owing to sepsis[8] secondary to bilateral leg cellulitis[9] and chronic leg ischaemia.[10]

15. This report concerns the care Mrs A received at the rest home in the last two weeks of her life in Month5 and early Month6 — in particular, concerns about the assessment of her delirium, and the lack of escalation and critical thinking, including pain management once she began to deteriorate from 31 Month5.

Month1–Month5

16. As noted above, Mrs A had multiple co-morbidities, including repetitive infections on both of her legs, leaking oedema,[11] ulcerations on her left lower leg, and ulcers on her ankle and foot, which were present on her admission to the rest home. Mrs A's osteoarthritis caused severe pain in both hips and limited movement in her legs and hips,[12] and she experienced severe pain when she was moved.

17. In Month1, Mrs A developed pressure injuries on her sacral area[13] and she was prescribed opioid painkillers[14] to be taken at night to assist with moving her onto her bed. In Month2 and Month3, further pressure injuries developed on her left upper thigh and both buttocks.

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[1] A slow and progressive decline of kidney function.
[2] A chronic condition that affects the pumping power of the heart muscles.
[3] Heart problems caused by narrowed heart (coronary) arteries that supply blood to the heart muscle.
[4] A condition that affects joints.
[5] A disorder that causes the blood vessels outside the heart and brain to narrow, block, or spasm.
[6] A legal document that sets out who can take care of a person's personal or financial matters if that person is unable to.
[7] Relevant months are referred to as Months 1–6 to protect privacy.
[8] A potentially life-threatening condition caused by the body's response to an infection.
[9] A bacterial skin infection.
[10] Reduced blood supply to the limbs.
[11] A build-up of fluid in the body that causes swelling.
[12] Noted in Mrs A's care plan — a live document that was updated on 2 October 2019.
[13] The rest home noted that the pressure areas were stage 1 pressure injuries.
[14] 2.5mg oxycodone hydrochloride.

In Month2, she was prescribed a higher dose of the same painkiller[15] for pain when needed. By Month4, these stage one pressure injuries on her sacrum had increased in size (redness) to the tops of both of her legs.

18. On 4 Month4, Dr D[16] prescribed antibiotics for a wound infection in both of Mrs A's legs, and had a discussion regarding her medication. Dr D noted in the progress notes: "[C]hat re fentanyl patch[17] but says went 'dullaly' when used in hospital. Prefers 3x daily oxynorm[18]; ok also option of SR morphine." Dr D told HDC that Mrs A knew her own mind and how to express her wishes, and was always reluctant to take strong pain relief. In response to the provisional opinion, Mrs B told HDC that her mother was unable to tolerate morphine-based medications and previously had had reactions to high doses, and wanted to have a "clear head" given her falls risk, which was why she was reluctant to take these.

19. On 8 Month4, RN E[19] reviewed Mrs A's wounds and documented[20] ulcerations on both legs; slough[21] on the ankle; and necrotic wounds on three toes (that most likely were arterial). RN E also noted a superficial wound on the right buttock where the stage one pressure injury was situated, and tenderness on the sacrum.

20. Mrs A was competent to make decisions for herself. Her interRAI[22] assessment on 18 Month5 assessed her as making consistent decisions, which were reasonable and safe. Her care plan noted that she tended to decline pain relief when offered, and that staff needed to give further encouragement and to remind Mrs A about the importance and consequences of not taking the pain relief and not sleeping on her bed. Ms K, General Manager at the rest home, told HDC that Mrs A's decisions to decline medication were discussed with Mrs A and her family.

21. Mrs A did not have an Advanced Care Plan. Ms K told HDC that they had planned to have a meeting with Mrs A's family to discuss advanced care planning. Dr D told HDC that Mrs A had always been extremely reluctant to go to the public hospital, and preferred to stay at the rest home.

Wound infection — 19 Month5

22. As part of her routine care, it was recorded that on 19 Month5 Mrs A's baseline blood pressure was 127/51mmHg,[23] her temperature was 36°C,[24] and her respiratory rate was 18

[15] 5mg oxycodone hydrochloride.
[16] Mrs A's GP of 11 years.
[17] A medicine used to relieve severe pain.
[18] OxyNorm capsules contain oxycodone hydrochloride. Oxycodone belongs to a group of medicines called opioid analgesics.
[19] DHB wound care nurse practitioner.
[20] In the progress notes.
[21] Dead tissue.
[22] InterRAI assessments are comprehensive clinical assessments that focus on a person's function. They are specifically designed to show the assessor opportunities for improvement and/or any risks to the person's health, which then form the basis of a care plan.
[23] This reading indicated that Mrs A's blood pressure was slightly lower than the norm.
[24] Within the normal range.

breaths per minute.[25] At 1.17pm, RN L noted in the progress notes that she had taken a wound swab, which was sent to the community medical laboratory.

23. RN E conducted a routine follow-up at 3.30pm to review Mrs A's leg wounds and sacral pressure injury. RN E noted an improvement in the oedema and fluid in Mrs A's lower legs, and that ulceration[26] was still present. The plan for Mrs A's wounds was documented as:

> "Pressure relieving strategies as able, continue dressings and monitor for increasing signs of shearing/friction.
>
> Encourage limb elevation as able and document response. Continue dressing regime to both legs — BD combines, (aquacel[27] to ulcers, change daily or BD if saturated) and toe to knee crepe — dermol[28] to areas of eczema and bleach baths twice a week. Stop 3% salicylic acid in soft paraffin for now apply daily moisturiser to both legs. Update family and GP."

24. After a discussion with RN E, Dr D prescribed antibiotics[29] for prevention of infection in the skin around the chronic ulcers.[30] At this point, because the wound swab results were pending, it was not known whether Mrs A had an infection.

25. At 4.10pm, RN L noted in the progress notes: "CELLULITIS/SOFT TISSUE/WOUND INFECTION: Yes."

26. Despite Mrs A's wound swab having identified bacteria,[31] RN L did not document this detail about Mrs A's wound infection in the progress notes or the Wound Care Plan for 19 Month5, nor did any other staff enter the information subsequently.

Care between 20 and 26 Month5

27. Between 20 and 26 Month5, no particular concerns were noted in Mrs A's care notes. The only note made in Mrs A's progress notes was on 23 Month5, outlining that Mrs A had declined a bleach bath because it caused her pain, that she had more small wounds on her left foot, and that her pain was more compared to the previous week.

27 Month5

28. RN L documented[32] in the progress notes that she checked on Mrs A at the start of her shift (at 6.45am), and Mrs A was "alert and conversant but complained of severe pain on her bilateral hip and foot". RN L recorded that Mrs A had a pain score of 8/10, and that she agreed to take medication. RN L checked Mrs A 30 minutes after she was administered the analgesia, and her pain score had reduced to 4/10. RN L documented that Mrs A's wounds

[25] Within the normal range.
[26] A break on the skin with erosion of the tissue.
[27] A type of dressing.
[28] An antimicrobial and emollient (softening and moisturising) treatment.
[29] Flucloxacillin.
[30] Areas where underlying tissue damage has caused skin loss, leaving a raw wound.
[31] Beta-haemolytic streptococci.
[32] At 5.27pm.

on her foot and bottom had been cleaned and the dressings changed, but that Mrs A had complained of 8/10 pain during this. RN L also noted that Mrs A had agreed to take further analgesia at around 12.40pm.

29. At 1.30pm, Dr D reviewed Mrs A for a persistent cough, having been asked to do so by rest-home staff. He noted that Mrs A's appetite had reduced. He listened to Mrs A's chest (which was clear), confirmed that there were no signs of infection, and noted that her pulse rate and temperature were normal. Dr D also carried out the three-monthly review and noticed that Mrs A's leg ulcers had deteriorated slightly. He reported that Mrs A was alert and communicated normally, although she appeared tired. He noted that she was for pain relief as needed, and for protein drinks to supplement her diet.

30. RN L recorded that Dr D had attended at 1.30pm, and that a discussion had taken place with Mrs A about the importance of elevating her lower legs and keeping her bottom off the chair or changing position while sitting on the chair. RN L documented in the progress notes that she had contacted Mr C and asked to schedule a lifestyle review to discuss advanced care planning (a multidisciplinary meeting), and Mr C explained that he was unavailable that week and would call to let them know when he could come in. The rest home noted that previous lifestyle review meetings had been held with Mrs A, and later with Mrs A and Mr C. The minutes of these reviews indicated that advanced care planning was not discussed.

31. At 5.32pm, RN L made a note in the "Skin Assessment" part of the progress notes stating that Mrs A preferred to sit and sleep on her recliner chair most of the time because of the pain in her hips, but that staff were to encourage her to sleep on her bed, to change position, and to elevate her legs to lessen the oedema in her legs and feet.

28 Month5

32. Progress notes for the day describe Mrs A as tired with low blood pressure. At 3.30pm, her blood pressure had increased slightly,[33] her temperature remained at 36°C,[34] and her respiratory rate was 18.[35] At 5.45pm, RN L documented in the progress notes that she had checked on Mrs A at the start of her shift, and she was alert and conversant but was feeling sleepy. Mrs A's low blood pressure was noted. Staff informed RN L that at around 8.45pm Mrs A had vomited a small amount of clear liquid.[36] RN L checked on Mrs A and noted that she felt better after vomiting, and was drinking tea.

29 Month5

33. On 29 Month5, one progress note was made stating that Mrs A did not take her furosemide.[37] Other daily notes were made in the "Hourly SUPPORT" and "Hygiene" sections of Mrs A's notes.

[33] 107/53mmHg.
[34] Within the normal range.
[35] Within the normal range.
[36] Documented in the progress notes at 9.22pm by RN L.
[37] A diuretic, which helps to get rid of extra salt and water in the body.

30 Month5

34. On 30 Month5, an aged residential care nurse from the local hospice was at the rest home to mentor the nurses. She reviewed Mrs A's notes and recommended the Leecare[38] pain assessment tool to assess Mrs A's pain. This advice was followed, with the change to reporting pain using body language and behaviour rather than a numerical score. Pain charting using the Leecare pain assessment tool began on 30 Month5.

35. The progress notes document that Mrs A was in pain and discomfort after every bleach bath, and had declined the bleach bath and the use of giraffe equipment[39] for transfer.

31 Month5

36. At 2.36pm, RN M documented in the progress notes that both of Mrs A's feet had more open wounds and had been cleaned. RN M commented that Mrs A appeared very sleepy and claimed that she had been waiting for staff to assist her to the toilet, despite having been several times with the registered nurse and the healthcare assistant. RN M also noted that Mrs A was falling asleep while having a conversation with her.

37. RN F worked the afternoon shift (2.45pm–12am). She told HDC that she recalls that Mrs A was conscious and able to verbalise that she was sore when she mobilised. RN F told HDC: "I didn't recognise full signs of delirium aside from pain because [Mrs A] was still conversing with staff and RN during that shift, she was able to mobilise with assistance."

38. At 10.27pm, RN F documented in the progress notes: "[Mrs A is] conscious and coherent but informed RN that she is feeling sleepy."[40]

1 Month6

39. Progress notes at 12.45pm[41] note that Mrs A was moaning, had facial grimacing and a pain score of 8/10, had drunk 50ml, and her wound dressing had been changed. RN G[42] recalled that Mrs A refused pain relief on several occasions, and RN G thought that Mrs A had already taken her pain relief.

40. At 3.03pm, RN L emailed RN E and outlined that both of Mrs A's lower legs had declined, there were more raw areas on both of her feet with yellow slough, the ulcers had increased in size, and Mrs A was complaining of severe pain.

41. At 8pm, Mrs A's blood pressure was low,[43] her temperature was 36°C,[44] her heart rate was 61 beats per minute,[45] and her respiratory rate was 20.[46] Mrs A was moaning, and her pain

[38] A provider of systems for residential aged care.
[39] A standing hoist used to transfer a client.
[40] The medication chart documented that RN F gave Mrs A pain relief at 9.04pm.
[41] Documented by RN L (who worked between 11.15am and 3.15pm).
[42] Who worked between 12pm and 11.30pm.
[43] 97/56mmHg.
[44] Within the normal range.
[45] Within the normal range.
[46] Within the normal range.

score was recorded as 6/10.[47] Mrs A told RN G that she had already had three doses of pain relief in the last hour, which was not correct. RN G noted that Mrs A was very confused and disoriented to time and place, and quite lethargic.

42. The notes do not record whether the nurses considered that Mrs A was experiencing delirium.

43. The progress notes document that at around 8.05pm, Mrs B telephoned and spoke to Mrs A and RN G. Mrs B's recollection of the call with her mother was outlined in an email to the DHB, in which she explained:

> "When I spoke to mum, her voice was slurred, she was very confused at times and talking nonsense. I called the staff back and asked them to get her Dr to see her the next day, and that I would drive up from [my home]."

44. Mrs B stated that during her telephone call, "the [rest-home] staff [member] commented that [her] mum would not let them move her or stand her, she had had little to eat or drink the previous two days and [her] Mum told [her] she had not been to the toilet since 6pm the previous day, nearly 24hrs previous". Mrs B also recalled that her mother had told her that she had not passed urine for 24 hours.

45. A GP review was not arranged on this date.

2 Month6

46. At 1.40am, Mrs A was observed[48] rocking back and forth on her chair with clenched fists,[49] and attempts to wake her were unsuccessful. At 4.33am, Mrs A was still asleep on her chair with both fists clenched. At 6.38am, RN J documented in the progress notes: "[C]onversant but appeared confused. Unable to answer what was being asked. Unable to respond when asked if in pain."

47. RN I[50] recalled that RN J informed staff that Mrs A appeared to be confused. After the handover, RN I attended Mrs A and documented in the progress notes:

> "[Mrs A] monitored closely this morning as appears to be very confuse[d] overnight unusual for [Mrs A]. This morning [Mrs A] was sitting in her chair and appears to be very confuse[d] and in a lot of pain. Pain relief offered but declines. [Mrs A] has decline[d] all cares from staff this shift. [Mrs A's] eyes appeared to be gunky and sunken. Not orientated to place and not making sense when communicating."

48. A physiotherapist was asked to see Mrs A, as she was declining the giraffe hoist. At 10.03am, the physiotherapist documented in the progress notes:

[47] Documented in the progress notes by RN G.
[48] By RN J, who worked 10.45pm on 1 Month6 to 7am on 2 Month6.
[49] Documented at 3.06am.
[50] RN I worked between 6.45am and 5pm on 2 Month6.

> "S[ubjective]: Referred to see [Mrs A] regarding constant declination to use giraffe hoist as a transfer method. Staff say [Mrs A] will refuse and then attempt to independently mobilise with frame but is unable to stand due to pain.
>
> O[bjective]: Saw [Mrs A] sitting in chair, attempted to speak to [Mrs A] but could not hear. Eyes appeared gunky and sunken. She repeatedly rambled about being in hospital, spilling coffee, not eating. She used words in strange sequences to make sentences.
>
> A[ssessment]: [Mrs A] is an educated woman who would normally speak very well. Taking this into account along with her poor appearance I believe that she may have an infection of sorts and needs to be seen by a doctor immediately.
>
> P[lan]: Referred to RN for immediate doctor's review."

49. At 10.30am, RN I requested an urgent GP review. The communication form completed by RN L and sent with the fax request documented:

> "[Mrs A] is noted to be low mood this past 4 days and not eating well. Also noted declining pain relief despite having severe pain on lower legs and buttocks … This morning [Mrs A] was sitting in her chair, attempted to speak to [Mrs A], she could not hear. Her eyes appeared to be gunky and sunken. Very confuse[d] and not able to answer questions regarding daily routine. Not orientated to place, [Mrs A] thinks she is at the public hospital, spilling coffee. [Mrs A] used words in strange sequences to make sentences."

50. Dr D recalled that when he arrived to review Mrs A, she was confused, appeared disorientated, did not know where she was or the time of day, and had a lot of pain in her back. Dr D took Mrs A's vital signs, which were normal. He recalled that she had eaten little over the weekend and was refusing fluids that day. Dr D's notes stated: "Delirium ++ confused and disorientated, time and space. Thinks she is covered in paint."

51. Dr D said that following a discussion with Mrs B, they elected to admit Mrs A to the public hospital. At 2.22pm, Dr D telephoned the medical registrar and sent a referral to the public hospital.

52. RN H[51] recalled offering Mrs A a strong pain medication several times, but she declined and said she did not want it.

53. Ambulance service records show that RN I telephoned an ambulance at 3.41pm. RN I told HDC that she thought she called the ambulance earlier than 3.41pm. The ambulance service told HDC that Mrs A was assigned a lower priority because RN I informed them that Mrs A had seen a doctor and had a provisional diagnosis of possible delirium, and that it was safe for Mrs A to wait if an ambulance was not available to respond immediately.

[51] RN H began her shift at 2.45pm.

54. At 3.50pm, Mrs A was given pain relief[52] but it was ineffective. RN H retrospectively documented[53] in the progress notes: "She was crying in pain. Her wound dressings on both legs were soiled but she declined to have them changed."

55. The ambulance service told HDC that there was a delay in dispatch to Mrs A because of higher priority incidents and meal break requirements. The ambulance service stated that a welfare call was made at 4.14pm, and they were told that Mrs A's condition was unchanged, and the ambulance service advised the rest home to call 111 if her condition changed. A second welfare call was made at 4.58pm, when the ambulance service was told that Mrs A's condition had changed and that her pain was worse and they needed to attend Mrs A as soon as possible. Therefore, Mrs A's priority level was increased at 5.00pm.

56. The progress notes record that Mrs B arrived at dinnertime around 5pm. Mrs B told the DHB that when she entered Mrs A's room, she immediately noticed a "rotting skin" smell, and that a fly was constantly trying to land on Mrs A's bandages and the bandages had large areas of ooze that had soaked through. Mrs B stated:

> "While waiting for the ambulance I noticed one of mum's toes was a dark purple colour. When I folded the bandage back I was shocked to find all of the toes the same colour on both feet."

57. In response to the provisional opinion, the rest home told HDC that the discolouration of Mrs A's feet may have been exacerbated by her peripheral vascular disease (as well as the shutdown of her peripheries related to her rapid deterioration).

58. Mrs B stated[54] that before the ambulance arrived, her mother "was unable to move at this stage and was in a lot of pain".

59. The ambulance arrived at 5.25pm and left the rest home at approximately 6.26pm. The ambulance personnel found Mrs A in her room slumped on her chair. Mrs A was alert but confused, and did not obey commands and was in visible pain. Mrs A's pulse was 60 beats per minute, her respiratory rate was 20,[55] her oxygen saturation level was 90%,[56] and her temperature was 35.3°C.[57] The Ambulance Care Summary documented only her systolic blood pressure, which was 90mmHg.[58] Fentanyl was administered intravenously, and the ambulance arrived at the Emergency Department at the public hospital at 6.49pm.

[52] Oral liquid oxycodone.
[53] At 9.51pm.
[54] In an email to the DHB dated 18 Month6.
[55] Within the normal range.
[56] Below the normal range for adults (94–99%).
[57] Below the normal range.
[58] Low blood pressure.

Month6

60. The public hospital discharge summary outlined that Mrs A presented with sepsis[59] secondary to bilateral leg cellulitis and chronic leg ischaemia, and this was confirmed by her blood test results. Unfortunately, Mrs A did not respond to treatment, and she passed away at 4.15am on 3 Month6.

DHB review

61. On 3 Month6, following a complaint from Mrs B, the rest home asked the DHB to review Mrs A's rest-home notes and the Emergency Department notes. The DHB undertook a review and made recommendations, and provided a copy of its report to Mrs A's family on 17 December 2019. The review noted the following:

- The cause of escalating frequency and intensity of pain was not investigated.
- Follow-up and monitoring associated with wound deterioration was not robust.
- No fluid charting was commenced after the need for increased food and fluid was noticed.

Rest-home policies

62. The rest home had policies regarding:

- Wound Care, including wound care escalation guidelines;
- Dietary Policy, including requirements for fluid charting;
- Medicines Management; and
- Lifestyle Reviews.

63. The policies are included as Appendix B.

Responses to provisional opinion

Mrs B

64. Mrs B was given the opportunity to respond to the "information gathered" section of the provisional opinion, and her comments have been incorporated into this report.

65. Mrs B highlighted her concerns that at times she was not contacted about her mother's care, and feels that staff need more training, and need to update their knowledge on care for residents with specialised needs, such as her mother.

The rest home

66. The rest home was given an opportunity to respond to the provisional opinion, and its comments have been incorporated where relevant.

67. The rest home acknowledged that there were missed opportunities and shortcomings in the standard of care provided in Mrs A's last 24 hours. The rest home offered its sincerest

[59] A potentially life-threatening condition caused by the body's response to an infection.

apologies for the distress caused to Mrs A and her family, and said that it deeply regrets the events that occurred.

68. The rest home also told HDC that it fully agrees that Mrs A's delirium was not identified quickly enough in the final 24 hours, and that appropriate care may not have been provided in a timely manner. The rest home noted the complexities of recognising delirium and sepsis, and provided examples of research into this.

Relevant standards

69. The Health and Disability Services Standards NZS 8134.1.3:2008 (NZHDSS) state:

> "Service Provision Requirements Ngā Whakaritenga Whakaratonga
>
> Standard 3.3 Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.
> …
>
> 3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer."

Opinion: Rest home

70. As a healthcare provider, the rest home was responsible for ensuring that services were provided to Mrs A in accordance with the Code of Health and Disability Services Consumers' Rights (the Code) and the NZHDSS standards outlined above.

71. Mrs A was an elderly woman with multiple co-morbidities. This meant that she was particularly susceptible to rapid deterioration in her health, and was dependent on nursing staff to maintain her well-being on a day-to-day basis. Mrs A was reliant on staff both to monitor her health conditions and to respond appropriately to signs of deterioration. This case has highlighted the importance of critical thinking in a rest-home setting, including nursing staff assessing overall symptoms (rather than assessing them in isolation), and recognising their cumulative impact as being indicative of a more significant problem warranting further intervention.

Care provided 31 Month5 to 2 Month6 — breach

Recognition, assessment, and escalation of deterioration and delirium

72. Mrs A was competent. On 31 Month5 she began exhibiting signs of confusion. On 1 Month6, registered nurses documented that Mrs A was confused, disorientated to time and place,

and felt lethargic. Mrs B spoke to her mother at approximately 8pm, and recalls that Mrs A was "talking nonsense", her voice was slurred, and she was confused.

73. Between 1.40am and 4.33am on 2 Month6, a nurse made attempts to wake Mrs A but was unsuccessful. At 6.38am, the nurse noticed the extent of Mrs A's confusion and informed the day-shift nurse. Approximately three hours later at 10am, a physiotherapist observed that Mrs A was not acting and communicating in her usual manner, and informed nursing staff that she required an urgent GP assessment.

74. My expert advisor, RN Rachel Parmee, considered that Mrs A's confusion, along with sleepiness, lack of appetite, and no urinary output, were obvious signs of rapid deterioration and acute delirium. RN Parmee noted that the standard of care, especially in the care of older adults, is that registered nurses are familiar with the signs and symptoms of delirium and respond immediately. She advised that whilst Mrs A's deterioration was rapid, it is within the scope of practice of a registered nurse to be able to assess delirium and sepsis rapidly. RN Parmee considers that in relation to the assessment of Mrs A's delirium, there was a severe departure from the accepted standard of care.

75. There are two concerning features with the care described above. First, even though nursing staff noticed and documented changes in Mrs A's condition, such as confusion, disorientation, and lethargy, there was a lack of critical thinking that this could indicate possible deterioration. Secondly, owing to the lack of recognition of the significance of Mrs A's symptoms, nursing staff failed to respond and escalate Mrs A's deterioration in a timely manner. As a result, Mrs A experienced unnecessary pain and suffering.

Pain management

76. Mrs A often refused to take the pain medication that was offered to her, and she had the right to do so. However, her pain still needed to be assessed and monitored appropriately on a regular basis, and appropriate pain relief should have been made available.

77. RN Parmee advised that during the period 19 to 30 Month5 there were no departures from accepted standards in terms of the management of Mrs A's pain relief. Mrs A was given an opportunity to discuss her reasons for refusing pain relief with nurses and her GP. She appeared to be in control of her pain management and made informed decisions, though contrary to advice at times.

78. RN Parmee noted that as Mrs A's capacity to make decisions changed rapidly with the onset of delirium related to sepsis, there also needed to be a change in the approach to the assessment and management of her pain relief. As Mrs A's delirium progressed, her pain was measured using the Leecare pain assessment tool, which referenced her body language (eg, facial grimacing and moaning), which was appropriate.

79. RN Parmee commented that in light of the information from monitoring, and Mrs A's state of delirium, there needed to be alternative pain-relief measures available, such as different routes of administration (eg, subcutaneous morphine or transdermal fentanyl). RN Parmee considered that these alternative measures could have been obtained quickly using a verbal

telephone order or remote charting by the GP if they had not been charted as "as required" pain relief. Subcutaneous access would have been possible, if Mrs A was unable or unwilling to swallow.

80. RN Parmee noted that the situation changed when Mrs A's ability to make informed decisions about pain medication decreased, and the intensity of her pain increased rapidly when she experienced acute delirium in response to her body's declining response to infection (evidenced by blood test results while she was in the public hospital). RN Parmee advised that it was a severe departure in terms of nurses not recognising the onset of delirium (as noted above) and the need for immediate consultation with the GP and implementation of alternative pain relief and hydration measures.

81. I agree with this advice. As outlined above, I am critical of the registered nurses' inability to recognise delirium and sepsis and respond appropriately. This failure meant that Mrs A did not receive appropriate pain relief when she was unable to communicate or make decisions herself in her delirious state.

Lack of a food/fluid intake record during this period

82. During Mrs A's admission to the rest home, her dietary requirements were to eat a nutritious heathy balanced diet, and she did not require a food and fluid intake record. Prior to 31 Month5, Mrs A had no issue meeting her nutritional and hydration requirements.

83. It is noted in the progress notes that Mrs A's food and fluid intake decreased between 31 Month5 and 2 Month6. However, the decrease is unknown because a food/fluid intake record was not commenced.

84. RN Parmee commented that the lack of food and fluid intake from 31 Month5 to 2 Month6 appears to have been a significant change to Mrs A's usual pattern. RN Parmee advised that during this time it would have been appropriate to commence input and output monitoring, and that this was particularly important as along with this change in eating and drinking, Mrs A told her daughter at 8pm on 1 Month6 that she had not passed urine for 24 hours. RN Parmee said that if a dedicated record had been in place, this would have provided an indication of the dehydration and electrolyte imbalance that occurred.

85. RN Parmee advised that this was a severe departure in staff not recognising and monitoring a significant acute change. She noted that moreover, this was not picked up as an indication that there were other changes, which could have been linked to form a picture of an acute situation requiring intervention.

86. I agree with this advice. If a food and fluid record or input/output monitoring had been commenced for Mrs A when she started to reduce her food/fluid intake, the reduction would have been clear to all staff caring for Mrs A, and may have triggered an escalation sooner by the nursing staff, and more timely intervention.

Other issues

Lack of Advanced Care Plan in place

87. Mrs A did not have an Advanced Care Plan. The General Manager told HDC that they had planned to have a meeting with Mrs A's family to discuss advanced care planning.[60] Dr D told HDC that Mrs A had always been extremely reluctant to go to hospital, and preferred to stay at the rest home. On 27 Month5, RN L contacted Mr C and attempted to schedule a lifestyle review. The appointment to undertake the review was in the process of being arranged.

88. RN Parmee noted that it is accepted practice that an Advanced Care Plan be in place, and should be part of the initial care planning and admission process of a patient. The development of an Advanced Care Plan should take place while the person is competent and able to voice their preferences.

89. RN Parmee accepted that there were plans in place to discuss an Advanced Care Plan, and that the GP had had initial discussions with Mrs A about her preferences. RN Parmee said that she is unable to speculate whether the existence of an Advanced Care Plan would have altered Mrs A's final pathway, but noted that there would have been documented clarity around her wishes, particularly in relation to palliative-care measures and where these would take place.

90. An Advanced Care Plan on record would have meant that Mrs A's wishes for her palliative care, and her previous comments that she did not want to be admitted to hospital, would have been readily to hand and therefore easily referenced and taken into account by staff caring for her when she became increasingly delirious and unable to make informed decisions for herself. Completion of Advanced Care Plans is important. I agree with RN Parmee's advice, and it is disappointing that Mrs A's wishes in relation to palliative-care measures and where these would take place were not documented.

Conclusion

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

- The failure to recognise and assess her sudden onset of delirium.
- The lack of arrangement of alternative pain-relief measures, and therefore the lack of appropriate pain management between 31 Month5 and 2 Month6.
- The failure to commence a food and fluid chart or monitor input/output, which would have identified a significant acute change and likely dehydration sooner.
- The lack of an Advanced Care Plan on record, which meant that Mrs A's wishes for her end-of-life care were not documented and were not taken into account.

[60] This plan was documented in Mrs A's progress notes.

92. Accordingly, I find that the rest home did not provide Mrs A services with reasonable care and skill, and breached Right 4(1) of the Code.[61]

Wound care — adverse comment

Wound infection

93. On 19 Month5, Mrs A's wounds were swabbed and bacteria (beta-haemolytic streptococci) was identified. RN Parmee noted that the accepted practice, when documenting an infection, is to include all information related to the description and documentation of a wound in the wound care plan. Mrs A's Wound Care Plan was not updated once the presence of an infection had been identified clinically.

94. RN Parmee commented that the lack of documentation of Mrs A's wound infection was a mild departure in terms of the description of the infection. I accept RN Parmee's advice, and remind the rest home of the importance of updating care plans when situations change.

Wound dressing

95. RN Parmee noted that there was no departure in terms of the management of the wounds once the infection of 19 Month5 was identified. RN Parmee commented that the clinical notes and photographs provided indicate that Mrs A's wound was dressed according to the wound care nurse practitioner's advice. I accept this advice.

96. Mrs B was concerned that Mrs A's wound dressing had not been changed for two days prior to her transfer to the public hospital. Mrs A's dressings were changed on 1 Month6, and a deterioration was noted in the progress notes and a referral was made to the wound care nurse practitioner for further input.

97. On 2 Month6, Mrs A's dressings were not changed prior to transfer to the public hospital. RN Parmee commented that the ideal practice would have been to re-dress Mrs A's wounds, particularly in light of the excessive ooze. However, given the circumstances of extreme pain and delirium, it may not have been in Mrs A's best interests. Once appropriate pain relief had been administered (in the ambulance and hospital settings) it was possible to access Mrs A's wounds to re-dress them. RN Parmee advised that not changing Mrs A's dressing was a mild departure, but that this needed to be viewed in the context of her pain, rapid deterioration, lack of immediate access to alternative pain relief, and refusal to have her dressing changed.

98. RN Parmee explained that the photograph taken on 1 Month6 showed marked deterioration, but not to the extent found on admission to hospital the next day. The wound care nurse practitioner commented that the breakdown and discolouration of Mrs A's feet was likely to be related to the shutdown of her peripheries related to her rapid deterioration. RN Parmee advised that this seems to be a reasonable conclusion given the rapidity of the shutdown of Mrs A's bodily systems.

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

99. On balance, I agree that the deterioration of Mrs A's feet observed on 2 Month6 was related to her rapid deterioration, and, given the level of pain Mrs A was experiencing, and that the rest home had not provided Mrs A with an alternative method of pain relief, I am mildly critical of the decision not to change her dressings on 2 Month6. However, I note and agree with RN Parmee's comment that the inability to dress Mrs A's wounds on this date may have been prevented by early detection of her delirium, and access to alternative pain-relief methods (as discussed above).

Changes made since events

100. The rest home has reflected on feedback from residents, family, external agencies, and HDC's expert advisor. Since the events in 2019, the rest home has made the following changes:

- Imbedded the Health Quality & Safety Commission (HQSC) Frailty Care Guidelines into all registered nurses' day-to-day work, and utilised them as the basis of case studies, care evaluations, and discussions regarding residents, including when food/fluid balances should be completed.
- Introduced:
  - A STOP and WATCH tool, which is used by healthcare assistants and clinical staff when reporting changes in patients' clinical conditions.
  - The use of SEPSIS Trust NZ's pre-hospital sepsis screening and action tool for both assessments of sepsis and informing ambulances of life-or-death situations including "think, could this be sepsis".
  - Ongoing hospice nurse visits for education and mentoring for all registered nurses.
  - Case presentations/discussions at the registered nurses' fortnightly forum.
- Changed the six-monthly multidisciplinary meeting form to include:
  - Physician Orders for Life-Sustaining Treatment initial treatment orders "goal of treatment".
  - Advanced Care Plan — specific treatment and care preferences.
  - Pain management review.
- Added "recognising dehydration" to the rest home's education plan.
- Utilised the HQSC Shared Goals of care in the aged residential care suite of documents.
- Added "swab/spec taken" onto the Leecare infection control form (to assist nurses in checking for swab results) and links to the infection control report.

In addition, it provides an Advanced Care Plan booklet to all new admissions as part of the admission package.

101. The rest home also provided the following further education/training:

- Mandatory completion by registered nurses of modules by the DHB's online learning, covering sepsis, delirium, and the deteriorating resident.
- Education to all registered nurses on "Delirium (Preventing, Identifying, Assessing and Managing)".

Recommendations

102. I recommend that the rest home:

a) Provide a written apology to Mrs A's family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr C and Mrs B.

b) Provide an update on the implementation of the Leecare electronic system, including whether the delirium detection tool and intervention tool have been introduced. The rest home should provide this information to HDC within one month of the date of this report.

c) Conduct an audit of patient records over the preceding month from the date of this report, of staff compliance with the rest home's policies — in particular, compliance with the following policies:

- Frailty Guidelines policy
- STOP & WATCH tool
- Sepsis screening & action tool
- Use of Advanced Care Plans.

The results of the audit are to be reported to HDC within six months of the date of this report, including any remedial actions to improve compliance and the effectiveness of those changes.

d) Within three months of the date of this report, provide evidence of the following training provided to staff, outlined in paragraph 101 and as follows:

- Completion of the DHB's online learning modules covering sepsis, delirium, and the deteriorating resident.
- Education provided to all registered nurses on "Delirium (Preventing, Identifying, Assessing and Managing)".
- Completion of the Hospice Clinical Nurse Specialist ARRC Liaison "train-the-trainer" national Advanced Care Plan Course, which when completed will be disseminated to all registered nurses. In response to the provisional opinion, the rest home advised that this course had been cancelled by the organiser and not rescheduled.

In light of this, I recommend that the rest home consider attendance at a similar course, relevant to advanced care planning.

e) Schedule refresher education for all rest home nursing staff on the following topics, and schedule regular and ongoing education sessions every two years. Evidence of this should be provided to HDC within three months of the date of this report:

- Onset of delirium and sepsis.
- Escalation of care for deteriorating residents.
- Advanced Care Plans.
- Documentation of wound infections and laboratory results (use this case as a basis for training).
- Recognising dehydration and when to begin hydration monitoring and reporting of significant changes.

Follow-up actions

103. 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 HealthCERT (Ministry of Health).

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

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from aged-care nursing advisor Ms Rachel Parmee:

> "The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by [the rest home] was reasonable in the circumstances and why.
>
> With comment on:
>
> 1. Whether the acute infection of the wound identified on 19 [Month5] was managed appropriately.
> 2. The timeliness of recognising and escalating her deterioration/neurological changes 31 [Month5]–2 [Month6].
> 3. Whether [Mrs A's] pain management was adequate/appropriate during 19 [Month5]–2 [Month6] (inclusive).
> 4. Whether the management of [Mrs A's] food and fluid intake, including not having a food/fluid intake record during [Month5] and [Month6] was adequate/ appropriate.
> 5. Whether it was reasonable that [Mrs A's] wound dressings had not been completed on 2 [Month6].
> 6. The adequacy of the use of Leecare notes for the purpose of short-term care plans in relation to her changing condition — such as wound deterioration, vital signs, mobility, food/fluid intake.
> 7. The adequacy of the short-term care plan/Leecare notes completed for the wound infection.
> 8. Whether an advanced care plan or conversation with her/family was indicated during this timeframe, and the timeliness of arranging such a discussion.
> 9. Whether the care provided by the wound care specialist was adequate/ appropriate.
> 10. The timeliness of [Mrs A's] transfer to hospital.
> 11. Any other matters that I consider warrant comment.
>
> For each question I am asked to advise:
>
> a. What is the standard of care/accepted practice?
> b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.
> c. How would it be viewed by my peers?

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

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

1. Letter of complaint received 28 November 2019.
2. [The rest home's] responses dated 16 January 2020 and 27 May 2020, respectively, and enclosures including clinical records covering the relevant period.
3. Clinical records from [the DHB] covering the relevant period.
4. Comments from [Dr D].
5. Clinical records and response from [the ambulance service] covering the relevant period.

3. Background

[Mrs A] ([in her nineties] at the time of events) was a resident at [the rest home]. She had several co-morbidities including bilateral lower leg ulcers, chronic renal failure, congestive cardiac failure, ischaemic heart disease, osteoarthritis, and peripheral vascular disease.

The concerns raised primarily relate to the care provided to [Mrs A] in [Month5] and [Month6] in relation to wound care and the management of her pain, food and fluid intake and deterioration.

[Mrs A] was transferred to [the public hospital] on 2 [Month6] via ambulance and died on 3 [Month6].

Review of Documents

4. Whether the acute infection of the wound identified on 19 [Month5] was managed appropriately

On the 19th [Month5] the wound care Nurse Practitioner, [RN E], conducted a routine follow up to review [Mrs A's] wounds. She notes an improvement in the oedema and fluid in [Mrs A's] lower legs with ulceration still present. Her plan is noted as follows:

Plan:

Pressure relieving strategies as able, continue dressings and monitor for increasing signs of shearing/friction.

Encourage limb elevation as able and document response. Continue dressing regime to both legs — BD combines, (aquacel to ulcers, change daily or BD if saturated) and toe to knee crepe — dermol to areas of eczema and bleach baths twice a week. Stop 3% salicylic acid in soft paraffin for now apply daily moisturiser to both legs. Update family and GP.

There is no indication in this entry that [Mrs A] was suspected of having a wound infection.

In his letter, dated 20 May 2020, [Dr D] states that

> *'[Mrs A] had been prescribed Flucloxacillin … after discussion with the wound nurse specialist … This was for prevention of infection in her skin around her chronic ulcers.'*

The prescription was intended for prevention and not treatment of infection and is a logical progression of the Nurse Practitioner's assessment and discussion with the GP.

The entry made by an RN at [the rest home] indicates that there was a new infection. In response to the question on the form about the nature of the infection:

'CELLULITIS/SOFT TISSUE/WOUND INFECTION' the RN has responded: Yes.

This response does not identify the nature of the infection as the question requires.

The RN also notes that a wound swab was taken and sent to the lab. The results of these swabs indicated streptococcus infection in both legs. The only evidence of this information was in the lab results in the clinical notes supplied by [the DHB].

The clinical notes and photographs provided indicate that the wound was dressed according to the Wound Care Nurse Practitioner's advice. The records indicate that the wounds were dressed on the 1st of [Month6] and that a deterioration was noted, and referral made to the Wound Care specialist for further input.

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

The accepted practice is that all information related to the description and documentation of a wound is included and that wounds are dressed according to the wound care plan. The wounds assessed and the findings are recorded and acted upon when necessary.

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

I believe there has been a mild departure in terms of the description of the infection. I do not believe there was a departure in terms of the management of the wounds once the infection had been identified.

b. How would it be viewed by your peers?

My peers in education and practice would agree with this

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

Ensuring that RNs are familiar with the context and rationale for decisions rather than making assumptions. In this case, the resident was prescribed antibiotics for prevention of infection rather than because an infection was suspected. This should then have been updated once the presence had been clinically identified. There needs to be a

requirement on the new infection form that the lab results are recorded when a specimen is taken and sent for culture.

5. The timeliness of recognising and escalating her deterioration/neurological changes 31 [Month5]–2 [Month6].

The progress notes supplied indicate that observations of [Mrs A's] deterioration were noted but no assessment for delirium or its cause was triggered. In her response [Ms K] states that the progress notes reflected that [Mrs A's] confusion had been noted along with her refusal to take medications, food, and fluids. [Mrs A's] daughter's observations indicate severe acute confusion contrary to [Mrs A's] usual status. This confusion along with sleepiness, lack of appetite and no urinary output were obvious signs of rapid deterioration and acute delirium.

[Ms K] refers to implementation of the Frailty Guide including delirium assessment and the STOP and WATCH form for Health Care Assistants. She also mentions the implementation of a sepsis assessment tool.

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

The standard of care, especially in the care of older adults would be that RNs are familiar with the signs and symptoms of delirium and respond immediately. In the case of [Mrs A], the contrast between her delirium and usual behaviour would have been particularly clear given the absence of dementia. The ability to distinguish between dementia, delirium, and depression, and respond appropriately are the hallmarks of assessment and care of older adults.

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

I believe there to have been a **severe departure** from the standard of care in this situation. While I accept that [Mrs A's] deterioration was rapid, I maintain that it is within the scope of practice of a registered nurse to be able to rapidly assess delirium and sepsis and respond appropriately.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

[Ms K's] implementation of the Frailty Guide and associated tools for RNs/ENs and HCAs along with education programmes goes a long way to ensuring that this situation does not reoccur.

6. Whether [Mrs A's] pain management was adequate/appropriate during 19 [Month5]–2 [Month6] (inclusive)

The management of [Mrs A's] pain presented significant issues for both [Mrs A] and those caring for her in terms of appropriate pain management. She was also in the unenviable situation of having severe osteoarthritis in her hips which prevented her from staying in a position that enabled her to elevate her legs and thereby decrease the effects of oedema and ulceration in her lower legs.

Her Care Plan notes:

[Mrs A] has severe pain on both hips due to osteoarthritis.

She is unable to move both hips and has limited movement on both legs. She is not in pain when she is sitting in her lazyboy chair. Upon movement/transfers, that's when she experiences severe pain.

It is noted on several occasions in the documentation provided, that [Mrs A] had strong opinions about the use of pain medication. It appears she had an aversion to opiate analgesia because of fear of losing control and often refused to take pain medication that was offered to her. She did not have cognitive impairment or mental health issues that prevented her from making informed decisions about adherence to medication regimes.

[Dr D's] notes and letter reflect this:

chat re fentanyl patch but says went dullaly when used in hospital. prefers 3x daily oxynorm; ok also option of SR morphine. (GP notes 04 [Month4])

GP letter — Reluctant to take strong pain relief (letter 27 May 2020)

[Ms K] mentions that [Mrs A's] decisions to decline medication were discussed with her along with her family and GP and that there was a plan in place to continue input from the Hospice nurse in helping to find ways to manage [Mrs A's] pain.

It appears from the progress notes that [Mrs A] did make decisions to take pain relief that was offered on occasion particularly around the acute pain of wound dressings.

It is also indicated in the progress notes that nurses gave encouragement and explanation which resulted in [Mrs A] taking analgesia and pain reducing.

The Medimap charts supplied indicated that [Mrs A] frequently took her night-time dose of Oxycodone and the higher dose PRN Oxycodone was taken once each day on the 1st and 2nd of [Month6].

[Mrs A's] daughter describes her mother as having a high pain threshold but notes that during the time that she was experiencing delirium and sepsis, she was expressing severe pain.

As [Mrs A's] capacity to make decisions rapidly changed with the onset of delirium related to sepsis there also needed to be a change in the approach to the assessment and management of her pain relief. [Ms K] mentions the possibility of altering [Mrs A's] careplan.

The methods used to measure [Mrs A's] pain were appropriate but not consistent. Her pain scores on her Hourly Support charts were recorded irregularly. The scores for the 31st [Month5] and 1st [Month6] were more regular and indicated that she scored consistently between 7/10 and 10/10.

As her delirium progressed her pain was measured based on her body language (e.g. facial grimacing and moaning) which is appropriate. As [Mrs A's] daughter noted, while she was in a state of delirium, she was unable to make decisions about her pain relief. On the 30th [Month5], a Hospice nurse recommended a 'more in-depth pain scale be utilised'. It appears this advice was followed with the change to reporting using body language and behaviour rather than a numerical score to measure pain.

In the light of the information from monitoring and [Mrs A's] state of delirium there needed to be alternative pain relief measures available such as different routes of administration (for example subcutaneous Morphine or transdermal Fentanyl). These could have been obtained quickly using a verbal phone order or remote charting by the GP if they had not been charted PRN. The report from [the ambulance service] is that these measures were taken, and IV fluids were administered leading to an improvement in [Mrs A's] condition. The use of IV access is not usually possible in a long-term care facility, but subcutaneous access is possible if the resident is unable or unwilling to swallow.

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

Standard practice is that pain is appropriately assessed and monitored, and that appropriate pain relief is made available to the resident. In a situation where a resident is no longer able to make decisions about taking pain relief or unable to take medication it is expected that measures to ensure that pain relief is administered via an appropriate route are undertaken.

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

I do not believe there was a departure in terms of the management of [Mrs A's] pain relief during the period 19th [Month5] to 30th [Month5]. It is evident that she was charted appropriate pain relief, this pain relief was offered according to the charting (regularly and PRN with records of pain scores). She was given opportunity to discuss her reasons for refusing pain relief with Registered Nurses and the GP. She appeared to be in control of her pain management and made informed decisions, though contrary to advice at times.

The situation changed when her ability to make informed decisions decreased and the intensity of her pain increased rapidly when she experienced acute delirium in response to the worsening of her body's response to infection (evidenced by blood test results while she was in [the public hospital]). I believe there was a severe departure in terms of nurses not recognising the onset of delirium and the need for immediate consultation with the GP and implementation of alternative pain relief and hydration measures.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

As stated above the measures taken to educate staff about the onset of delirium and sepsis and responses to these will go towards preventing a similar occurrence. As will be discussed later the use of an Advanced Care Plan could potentially have assisted decisions made at the time [Mrs A] became acutely ill.

7. Whether the management of [Mrs A's] food and fluid intake, including not having a food/fluid intake record during [Month5] and [Month6] was adequate/ appropriate

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

Standard practice is to assess and monitor nutrition as part of a holistic plan of care. [Mrs A's] nutrition needs were assessed on admission and indicated that she had no issues with meeting her nutritional and hydration requirements. Protein supplements were added to her diet in [Month2] in the light of her need for a high protein diet related to the care of her wounds. The lack of food and fluid intake from the 31st [Month5] through to the 2nd [Month6] appears to have been a significant change to [Mrs A's] usual pattern. While progress notes mentioned that [Mrs A's] food and fluid intake had decreased during this time it would have been appropriate to commence input and output monitoring. This is particularly important because it transpired that along with a sudden change in eating and drinking [Mrs A] told her daughter that she had not passed urine for 24 hours. If a dedicated record were in place this would have been picked up as an indication of the dehydration and electrolyte imbalance that occurred.

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

There has been a severe departure in recognising and monitoring a significant acute change. Moreover, this was not picked up as an indication that there were other changes which could have been linked to form a picture of an acute situation requiring intervention.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

The further education of RNs and caregivers in recognising dehydration and sepsis and knowing when to begin monitoring and report significant changes will help to prevent a similar occurrence.

8. Whether it was reasonable that [Mrs A's] wound dressings had not been completed on 2 [Month6].

The complaint from [Mrs A's] daughter indicates that [Mrs A's] dressings had not been done for nearly two days. It is noted in the progress notes that [Mrs A's] dressing had been done on the 1st of [Month6] and that there had been a deterioration in the status of the wounds leading to referral to the Wound Care Nurse Practitioner. The photograph taken on the 1st [Month6] indicates marked deterioration but not to the extent found on admission to Hospital the next day. Although the vascular medical staff stated the wounds would have been in the state in which they presented for a longer period of time than 1 day, the wound specialist commented that the breakdown and discolouration of [Mrs A's] feet was likely to be related to the shutdown of her peripheries related to her rapid deterioration. This seems to be a reasonable conclusion given the rapidity of the shutdown of [Mrs A's] bodily systems.

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

Ideal practice would have been to redress [Mrs A's] wounds particularly in the light of the excessive ooze. However, given the circumstances of extreme pain and delirium it may not have been in [Mrs A's] best interests. Once appropriate pain relief had been administered (in the ambulance and hospital settings) it was possible to access [Mrs A's] wounds.

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

There has been a mild departure in terms of not changing [Mrs A's] dressing, particularly as there was excessive seepage. However, this needs to be viewed in the context of her pain, rapid deterioration, lack of immediate access to alternative pain relief and refusal to have her dressing changed.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

The inability to dress [Mrs A's] wounds on 2nd [Month6] may have been prevented by having early detection of her delirium and access to alternative pain relief methods.

9. The adequacy of the use of Leecare notes for the purpose of short-term care plans in relation to her changing condition — such as wound deterioration, vital signs, mobility, food/fluid intake.

The Leecare electronic system for recording residents' files and progress notes was introduced to [the rest home] in [Month3]. [Ms K] explains that Leecare contains a series of electronic forms which act as both a report of a clinical event and short-term care plan. The documentation provided includes an example of this in the Wound Care Evaluation and Plans forms. Updates from these plans are recorded in the Progress notes. These forms staying open until resolved. She also mentions the planned addition of the STOP and WATCH form from the Frailty Care Guides to enable HCAs to alert RNs of changes to a resident's status.

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

Accepted practice is that a short term careplan is completed when there is an alteration to a resident's status such as a wound, infection, change in fluid balance. This provides a plan for staff to follow until the short-term change has been resolved. The Leecare system provides the tools to enable this to happen.

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

It appears that there has been no significant departure in the use of the Leecare system to record resident progress and short-term care plans.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

It is acknowledged that the system is new to [the rest home] and that a clinical audit is planned to review the use of the system. It would be useful to include further tools from the Frailty Guides in the system such as a delirium detection tool and intervention guides.

10. The adequacy of the short-term care plan/Leecare notes completed for the wound infection

The supplied Wound Care policy refers to the Leecare Wound/Skin Management Plan and Evaluation and the expected assessment, intervention, evaluation, and documentation for each wound. The documentation supplied indicates that in the case of [Mrs A's] wounds these expectations were met.

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

The expected standard is that the wound care policy for the institution is followed.

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

I do not believe there was a departure from expected practice in the management of [Mrs A's] wounds.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

No further recommendations.

11. Whether an advanced care plan or conversation with her/family was indicated during this timeframe, and the timeliness of arranging such a discussion.

[Mrs A] did not have an Advanced Care Plan. The reasons given for this appear to be that this was because she did not have dementia and was competent to make her own decisions.

In his letter [Dr D] states:

I knew that in the past [Mrs A] had always been extremely reluctant to go to the public hospital preferring to stay in the care of [the rest home], but was not well enough to make her own decision.

In [Mrs A's] care plan it states under Advanced Health Directives/specific wishes re care that: *[Mrs A] has no advance care plan on file.*

[Ms K] also notes that the Facility's Lifestyle meeting form was updated to include space for Advance Care Planning discussions. It had also been planned to have a meeting with [Mrs A's] family who had Enduring Power of Attorney to discuss Advanced Care Planning. The Hospice nurse had provided assistance in developing this process.

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

It is accepted practice that an Advanced Care Plan be in place and should be part of the initial care planning and admission process. The development of an Advanced Care Plan should take place while the person is competent and able to voice their own preferences not only in the presence of life-threatening illness or deterioration.

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

I believe there has been a moderate departure from accepted practice. I accept that there were plans in place to discuss an Advanced care plan and that the GP had had initial discussions with [Mrs A] about her preferences. I am not able to speculate that the existence of an advance care plan would have altered [Mrs A's] final pathway.

However, there would have been documented clarity around her wishes particularly in relation to palliative care measures and where these take place.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

[Ms K] has identified the plan to change the Lifestyle meeting to include Advanced Care plans and has enlisted the help of the Hospice in this process. I would also recommend that discussion of Advance Care Plans take place during the Inter Rai assessment and are recorded in the Care Plan.

12. Whether the care provided by the wound care specialist was adequate/ appropriate.

The Wound Care Nurse Practitioner first visited [Mrs A] on the 8th [Month4] following a referral for her services. She conducted a comprehensive assessment of [Mrs A] including reference to her osteoarthritis, mobility, and pain management. She provided a care plan and plan to review if no response to the plan.

She visited again on the 19th [Month5] to review the care plan and arranged for antibiotic cover to prevent infection.

She was contacted on the 1st [Month6] and arranged to visit the following week to review [Mrs A's] deteriorating wounds.

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

The standard of care is to refer wounds that are complicated or slow to heal to a wound care specialist. This is stated in the provided Wound Care Policy and Guidelines. The wound care specialist would then provide a care plan or advice and follow up as required.

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

I do not believe there was a departure from the standard of care in the care provided by the Wound Care Nurse Practitioner.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

No further recommendations.

13. The timeliness of [Mrs A's] transfer to hospital.

The decision to transfer [Mrs A] to hospital was made by her GP after being notified of her deterioration by the Nursing staff at 1030 on [2 Month6]. [Dr D] contacted the hospital and sent a referral at 2.22pm.

The ambulance timeline states that a call was received from [the rest home] at 15.41 (3.40pm) and [Mrs A's] transfer occurred at 17 52 hours (5.52pm).

The timeline which included the decisions to reassign [Mrs A's] transfer due to higher priority cases is included in the documentation. By the time the ambulance arrived [Mrs A] was hypotensive, and it was stated *that extrication was going to be a challenge.*

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

Standard practice for prioritising responses to calls to [the ambulance service] are described in their submission.

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

It does not appear that there was a departure from the expected standard in terms of the timeline and rationale provided by [the ambulance service] based on the information they were provided by [the rest home]. However, in the list of concerns provided by [Mrs A's] family they state that: *Ambulance informed family [Mrs A] should have gone to hospital sooner.*

In the light of the description of the status of [Mrs A] when the ambulance arrived describing her status as 'Potential threat to life' there may have needed to be more urgency in the information provided by [rest home] staff. It is difficult to comment about whether this would have changed the circumstances given the context provided by [the ambulance service].

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

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

Possibly some education to nursing staff about [the ambulance service] triage system such as that supplied by them for this case.

14. Any other matters that I consider warrant comment.

There are no other matters I consider warrant comment."

The following further advice was received from RN Parmee:

"Thank you for the opportunity to provide further advice on this case, for which I provided initial advice on 28th July 2020.

1. I have been provided with the following information:

    1. Cover letter from [the rest home]
    2. Nurse statements
    3. Job descriptions
    4. Rosters
    5. Certificates of Education
    6. Hospice RN statement
    7. Previous policies
    8. Photographs of [Mrs A's] feet provided by her daughter

2. I have been asked to comment, in the light of the new information, on

    1. The management of [Mrs A's]:

        a. Food and fluid intake
        b. Pain
        c. Wound care
        d. Assessment of delirium

    2. The adequacy of [the rest home's] 2017, 2018 and 2019 policies

    3. The adequacy of care provided by

        a. [RN F]
        b. [RN G]
        c. [RN H]
        d. [RN I]
        e. [RN J]
        f. [RN L]
        g. [RN M]

    4. Any other matters I consider warrant comment about the care provided by [Dr D] to [Mrs A] in 2019.

Review of documents

3. The management of [Mrs A's]

    a. Food and fluid intake
    b. Pain
    c. Wound care
    d. Assessment of delirium

Each of these factors are addressed in the response from [the rest home].

In each case the advice I have given is accepted and my recommendations put in place.

Specifically, the changes made are:

- The use of Frailty Care Guides and their advice on Food and Fluid Balance recordings and the introduction of recognising dehydration in staff education.
- Regular assistance from the Hospice and use of Frailty Care Guides to assist staff in review of residents' pain medication and, I assume, assessing and monitoring.
- The addition of a section for swab/spec taken to Leecare programmes and the linking of the Leecare and Medimap platforms.
- The use of a sepsis screening and action tool implemented to assist with diagnosis of delirium. It is also planned to add this tool to Leecare.

While my original advice, and responses to HDC's questions, around these aspects of [Mrs A's] care remain unchanged, I am confident that the reflection on her care and consequent changes in practice, education and documentation will prevent such events recurring.

4. Adequacy of [the rest home's] policies 2017, 2018 and 2019

Upon review of policies dated 2017, 2018 and 2019 it is clear that [the rest home] regularly updates its policies in line with changes in practice. This is particularly evident in the wound care policies and the use of validation questionnaires to ensure staff knowledge of the policies. My only other comment would be the need to incorporate advanced care planning into the admission and ongoing care planning process. Resuscitation decisions are clearly evident but there is also a need to include advanced care planning which covers much broader care needs. This is particularly relevant around decisions about hospitalisation, pain relief and antibiotics along with any spiritual or cultural needs.

5. The adequacy of care provided by specific RNs

The statements from each RN correspond with the information provided for my initial report. They all appear to have reflected on events related to [Mrs A's] care and accept that there were deficiencies in their assessment of delirium and dehydration. I do not believe the care provided by any specific RN contributed to the issues raised around [Mrs A's] care. Rather the issues were systemic, and I believe have been appropriately investigated and remedial measures put in place to ensure that all staff are appropriately educated.

6. Any other matters I consider warrant comment about the care provided by [Dr D] to [Mrs A] in 2019.

I do not have any further comment on the care provided by [Dr D].

I have chosen not to frame my advice around the 4 questions related to standard of practice, departures, peer agreement and recommendations as none of these have altered from those in my initial advice.

In conclusion I believe that the response from [the rest home] and accompanying documents do not change my initial advice. However, the investigation, reflection, changes in education and documentation are sufficient for me to believe that similar events will not recur."

Appendix B: Policies

The rest home's Wound Care Policy (March 2019) stated:

"All wounds will be managed as follows:

- All wounds will be assessed by an RN. Health care assistants (HCA) are responsible for reporting new wounds to the RN. The RN may delegate wound tasks to an Enrolled Nurse (EN) as per nursing council guideline direction and delegation[62] or appropriately trained Team leader (TL)/level 4 HCA.
- The Wound Assessment Form (WAF) will be used to complete a full assessment of the wound and patient related factors affecting wound healing. Exception; Cat 1A skin tears wound plan documented on accident/Incident form.
- The information collected on the WAF will be used to develop a wound care objective and wound care plan. Some residents will require treatment/care to address factors affecting wound healing, these will be addressed in the short or long term patient care plan.
- The wound care plan will be documented on the Wound Care Plan (WCP) form.
- Wound progress will be formally evaluated (measured and photo taken) every 2 weeks and progress will be documented on the Wound Evaluation Form (WEF). Observation of wound condition occurs at every dressing change.
- Wounds will be discussed monthly (or weekly if significant) at the 'RN/EN/TL' debriefs.
- The resident and wound may be re-assessed every 6 weeks as required (unless specifically direct[ed] otherwise by General Practitioner [GP] or Nurse Practitioner [NP] wound care).
- Wound Dressing Completed (WDC) form will be dated and signed every time the wound is re-dressed.
- There will be one set wound documentation (WAF, WCP, WEF, WDC) for each wound.

Wound care escalation: all wounds will be 'escalated' as follows:

- The HCA will report new/newly identified wounds to the RN.
- The RN will report all the following wounds to the Clinical Nurse leader (or delegate):
  - All necrotic wounds.
  - Monthly all wounds that
    - are unchanged.
    - have failed to reduce in size by 50%.

[62] Nursing Council New Zealand (2012) Competencies for enrolled nurses, NCNZ Wellington New Zealand.

— have deteriorated (increase in size or increase in devitalised tissue).
    - Wounds that have indications of infection (excessive exudate, blood or pus exudate, inflamed, red or hot surrounding skin, increased pain, pocketing).
- Clinical Nurse leader (CNL)/designated RN will refer the above wounds to the DHB Nurse Practitioner led wound care team for further assessment and treatment prescription (Ensuring GP fully informed)."

The Medicines Management Manual — Pain Management ([Month2]) states:

"POLICY:

- We take any concern of pain **very** seriously
- We aim to keep our residents free of pain and comfortable.
- When necessary residents will be referred to a pain specialist if doctor finds this necessary and makes the referral. (Hospice can also be utilised)
- We evaluate analgesic therapy effectiveness.
- Education of staff will include pain and management of pain, observation and prn medicines.

…

PROCEDURE:

When a resident complains of pain, the RN is to check the resident immediately.

- The once off headache might be treated with Paracetamol tablets, (if approved on PRN or standing order list), but if it is persistent pain we will have the resident seen by their doctor to make sure there is not something else going on. The doctor will assess the pain by examination (all PRN medication will be noted on medication sheet and in progress notes)
- Residents admitted on pain medication shall be on this regime until seen by GP
- Staff monitors, document and report breakthrough pain.
- Some residents may find it very difficult to express their level of pain. The RN/EN/TL will evaluate, observe, and record in progress notes for follow up by the Registered Nurse. The RN will complete a pain assessment form.
- Staff monitors the response to pain interventions (medication, positioning aids etc.) every half hour and full hour after administration/provision of treatment).
- Pain treatment, intervention, and the response will be documented, dated and signed in the resident's progress notes
- All pain is reported in progress notes and referred to GP or Nurse Practitioner. It will be his/her decision as to what to prescribe and what action to take, i.e. referral to pain specialist, alternative therapy, physiotherapy etc.
- Residents that are diagnosed with i.e. regular headaches will have PRN medication prescribed on their medication sheet. Any persistent pain should be referred to GP.

- Doctor or Nurse Practitioner will review these at least 3 monthly or more often when indicated.
- Pain assessment/history includes the information obtained from a pain assessment, the history of pain and its management and a history of analgesic use or other approaches.
- Information about pain and its management is provided to staff during orientation and on an ongoing basis.
- Residents are educated about pain and its management.
- Pain assessments are completed for all residents who receive regular pain medication.

NOTE: Chronic pain is not treated on PRN basis."

The Resident Nutrition and Hydration Policy ([Month5]) states:

"POLICY

To ensure adequate nutrition and hydration (fluid intake), ensuring optimal hydration and effective fluid balance is maintained appropriate to needs and age group.

PROCEDURE

The Registered Nurse is responsible for:

Overall monitoring of food/fluid intake and weight loss/gain.

Assessing hydration and nutrition and planning accordingly.

Where food and fluid intake is a concern, RN to instigate food intake record and complete 7 consecutive days. A fluid Balance chart is recorded for 3 days.

…

All clinical/therapy staff are aware of the following issue and are to report these to RN/CNL.

- Missed meals
- Not eaten all presented food

…

- Short-term care plans instigated if required identifying regular weighs are taken or a fluid balance/food chart started.
- RN follows up on information recorded.

…

Hydration

Indicators if optimal hydration is not met:

- Confusion, colour of urine (dark) lack of output, strong urine odour, cramps, irritability, dry mouth/lips, dry skin, headaches, constipation, dizziness.
- Increase in falls, pressure injury.

A fluid balance may be started, unless a decision otherwise has been made by GP or RN, when resident:

- Has vomiting and diarrhea.
- Has a temperature.
- Has UTI.
- Has not passed urine for a day.
- Shows signs of dehydration.

And any other indication that warrant a record to be kept.

Intake and output needs to be recorded clearly.

Review and monitoring of the chart should occur daily. TL/Senior HCA to check at end of each shift.

Any concerns reported to RN immediately.

Initially complete the chart for 3 days.

Offer fluids on regular basis. Try alternatives (when diet allows) such as jelly, ice blocks, and soup.

Re-assess every 24 hours and inform GP if no improvement noted."

The Lifestyle Reviews Policy (August 2018) states:

"POLICY

New residents will have an initial review within 3–4 weeks of admission.

All residents will have a review at least 6 monthly or more frequently if the need arises.

…
PROCEDURE
…
InterRai to be updated, with comments during review and action plan of any changes or goals to be noted in Residents Progress Notes or Careplan and Snap Shot.
…

To be discussed/checked at review;

Wishes for End of Life care — update annually."