The Kawerau Social Services Trust Board
Registered Nurse, RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC00678)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman at Mountain View Home and Hospital (Mountain View) in 2018. It highlights the importance of care coordination amongst staff, updating resident care plans, undertaking appropriate assessments as required, and documentation of care, concerns, and clinical reasoning. The woman's condition had deteriorated since 2017 because of a stroke. In 2018 nursing staff documented concerns regarding her condition that required regular monitoring and assessment. The woman then developed a pressure injury, and following observations of cellulitis[1] and a high-grade fever she was transferred to the public hospital where, sadly, she passed away.

2. The Deputy Commissioner found a pattern of failings involving multiple Mountain View staff. In particular, nursing staff failed to follow up on documented concerns and carry out the necessary assessments/observations as required, concerns about the woman's condition were not documented adequately, and the woman's pressure injury was not treated with the urgency it required. In addition, the woman's care plans were not up to date, and Mountain View failed to undertake an interRAI re-assessment for the woman following her stroke. Accordingly, the Deputy Commissioner found that Mountain View failed to provide the woman with an appropriate standard of care and breached Right 4(1) of the Code.

3. The Deputy Commissioner was also critical of a nurse's care of the woman during her final three days at Mountain View. The Deputy Commissioner found that the nurse did not take the required observations to monitor the woman's condition despite having noted herself the importance of ongoing monitoring at that time. The nurse also failed to ensure that the woman received hourly monitoring on her last morning at Mountain View, and her documentation in the woman's progress notes lacked sufficient detail.

4. Recommendations made to Mountain View included that it review/develop policies to better support nursing staff in their clinical decision-making, and use an anonymised version of this report as a case study for nursing staff development. The Deputy Commissioner also recommended that Mountain View provide regular education sessions to its staff in relation to monitoring a sick patient, short-term care plans, and documentation, and conduct audits of 20 current residents to ensure appropriate wound management, and that care plans/assessments are up to date.

[1] A spreading bacterial infection underneath the surface of the skin, characterised by redness, warmth, swelling, and pain.

Complaint and investigation

5. The Commissioner received a complaint from Ms B about the services provided to Mrs A by Mountain View Home and Hospital. The following issues were identified for investigation:

- *Whether The Kawerau Social Services Trust Board (trading as Mountain View Home and Hospital) provided Mrs A with an appropriate standard of care in 2018.*
- *Whether RN C provided Mrs A with an appropriate standard of care in 2018.*

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

7. The parties directly involved in the investigation were:

Ms B	Consumer's daughter
The Kawerau Social Services Trust Board	Provider
RN C	Registered nurse (RN)

8. Also mentioned in this report:

RN D	Facility Manager
RN E	Charge Nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse

9. Further information was received from:

The District Health Board (DHB)
The Ministry of Health
A medical centre

10. Independent expert advice was obtained from in-house aged-care advisor RN Hilda Johnson-Bogaerts (Appendix A).

Information gathered during investigation

Introduction

Mrs A

11. Mrs A, aged in her seventies at the time of events, was admitted to Mountain View Home and Hospital in 2016 after an interRAI[2] assessment identified that she had "high health instability" and required full-time care. Mrs A's medical history included diabetes, hypertension,[3] and atrial fibrillation.[4]

12. Mrs A's daughter, Ms B, stated that she had agreed with Mountain View that she could be contacted any time day or night regarding her mother if required; however, there is no record of this in Mrs A's clinical file.

13. From Day 5,[5] Mrs A's condition deteriorated, and following observations of cellulitis[6] and a high-grade fever on Day 7, she was transferred to the public hospital at 2.15pm. Sadly, Mrs A died a few days later owing to sepsis[7] secondary to cellulitis.

Mountain View

14. Mountain View is contracted by the DHB to provide hospital-level and rest-home-level care for up to 50 residents. At the time of these events it had 30 hospital beds, 18 rest-home beds, two dual-purpose beds,[8] and a four-year certification from the Ministry of Health.

15. The DHB's contract with Mountain View at the time of these events stated that Mountain View was required to implement and use interRAI as the primary means of assessing residents. Section D16.4A of the contract required Mountain View to use interRAI to reassess a resident if it identified that there had been a "significant change in that Resident's level of need and those needs [could] no longer be met by [Mountain View]". The contract further stated that registered nurses working at Mountain View were responsible for "ongoing re-assessment and review of Care Plans" in accordance with section D16.4A.

16. Mountain View's position description for the role of Charge Nurse at the time of these events stated that the Charge Nurse was expected to ensure excellence of resident care by, amongst other things, ensuring that "initial and ongoing InterRAI assessments [were]

[2] International Resident Assessment Instrument. InterRAI is the primary assessment instrument in aged residential care, 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.
[3] Abnormally high blood pressure.
[4] Very rapid uncoordinated contractions of the heart resulting in a lack of synchronism between heartbeat and pulse beat.
[5] Relevant dates are referred to as Days 1–7.
[6] Subcutaneous inflammation of connective tissue.
[7] A toxic condition resulting from the spread of bacteria or their toxins from a focus of infection.
[8] Dual-purpose beds are beds certified to provide both rest-home-level and hospital-level care, according to the type of care required by the resident.

performed and used to inform care planning", and ensuring that re-assessments were completed "when there [were] changes in level of cares".

17. Mountain View has a Facility Manager, who reports to the board of trustees, and a Charge Nurse, who has responsibility for oversight of clinical care. At the time of these events, RN D was the Facility Manager and RN E was the Charge Nurse. Between Day 4 and Day 7, RN D was covering for RN E, who was away for the weekend, and for the first three of these days RN E was able to be telephoned by staff should any matter arise that required the assistance of the Charge Nurse.

18. Mountain View also has a nurse who is responsible for completing and documenting "appropriate assessments, interventions and evaluations of wounds and [pressure injuries]", as well as "[coordinating] with the other RN's the right treatment and any recommendations by the Clinical Team". At the time of these events, this position was held by RN C.

Medical Centre

19. Mrs A had a regular general practitioner (GP) at a medical centre. On Day 1, Mrs A had a routine review by another GP at the medical centre. It appears that the rest home's message to the GP was limited to Mrs A's restlessness at night and difficulty sleeping, and that no other symptoms were raised. The GP prescribed zopiclone to aid with sleeping at night. Mrs A's regular GP saw her again on Day 2 for a medication review, and noted that she was "sleeping better [with] zopiclone".

Care at Mountain View

20. Mrs A had an initial interRAI assessment at Mountain View in 2016, and subsequently had three further routine interRAI assessments every six months.[9] Mrs A suffered a CVA[10] in 2017,[11] shortly after her final interRAI assessment, and the impact this had on her subsequent care is discussed later in this report.

Day 5

21. A caregiver told HDC that on the morning of Day 5 she noticed that Mrs A was delirious and that one of her legs was "red and warm to touch". The caregiver said that she rang the bell for RN C, and Mountain View's internal investigation into these events noted that the caregiver informed RN C about her findings. The caregiver told HDC that when RN C attended, she instructed her to "carry on with the cares, that she would come in later and check [Mrs A]". However, none of this is recorded in the progress notes. RN C stated that she was not told that Mrs A was delirious or had leg redness on that morning.

22. Progress notes from the previous day (Day 4) state that Mrs A "declined all breakfast and morning tea; and only ate ½ main for lunch". RN C told HDC that on becoming aware of

[9] The further interRAI assessments were completed in 2016 and 2017. Following each assessment, Mrs A's care plan appears to have been updated as required.
[10] Cerebrovascular accident — a stroke.
[11] Mrs A's GP documented: "Likely she had CVA last [week]."

Mrs A's poor dietary and fluid intake on the morning shift of Day 5, she took Mrs A's observations at 1pm "to rule out any possible small TIA[12] due to her past medical history". At 2pm, RN C recorded that Mrs A was dehydrated, had poor dietary intake, low blood pressure, and a fever of 37.7°C.[13] RN C noted that paracetamol had been given and fluids encouraged. She did not take any further observations, but documented a request for monitoring of Mrs A's condition to continue. At 3pm, RN C handed over care to the afternoon nurse, RN F.

23. In relation to her assessment of Mrs A's observations, RN C told HDC:

> "In the absence of any other symptoms, and considering [Mrs A's] poor dietary and fluid intake on that day and the hot weather in [the town] at that time, I suspected whether the observation results were due to dehydration."

24. RN C documented that she informed Mrs A's family of Mrs A's condition when they visited her in the afternoon on Day 5.

25. The caregiver for the afternoon shift documented that she had noticed redness on Mrs A's lower left leg and had informed RN F about this. In relation to the redness, the caregiver noted: "Not sure if or what has caused it, rubbing on chair/heat." RN F told HDC that he sighted the leg redness and thought that it was a heat rash caused by the hot weather, but did not document this. He stated that because of his assumption that the redness was a heat rash, he did not carry out further assessment, and handed over care and details of Mrs A's leg redness to the night nurse. RN F did not record any progress notes or take any observations during his shift.

26. Mountain View stated in a letter to RN F following these events that he should have carried out a full assessment, checked Mrs A's observations to follow up on RN C's concerns from the morning shift, checked her left leg, and documented those details in the progress notes.

27. The night nurse, RN H, told HDC that RN F handed over to her that Mrs A had redness on her left leg.

Day 6

28. On Day 6 at 5am, RN H documented that she had noted a "? pressure area" on Mrs A's left ankle. RN H took a photograph of the wound and applied a dressing. RN H told HDC that because she had no concerns about Mrs A's condition at that time, she did not feel it was necessary to perform any observations.

29. RN H stated that she did not follow up on RN C's noted concern from the previous morning that Mrs A was dehydrated, because she was told that Mrs A had had (an unspecified

[12] Transient ischaemic attack — an episode of deficient supply of blood to the brain, which usually results in temporary blurred vision, slurred speech, and paralysis, and is often predictive of a serious stroke.
[13] A temperature of around 37°C is considered normal. A mild fever is 38–38.9°C. A high fever is 39–39.9°C.

amount of) fluid intake on the later afternoon shift "due to repeated encouragement from staff".[14] RN H also stated that as Mrs A was settled and asleep at the start of her shift, she did not try to wake her up for fluids or to check observations because Mrs A had had unsettled nights in the previous weeks,[15] when she would try to get out of bed, which put her at a high risk of falling.

30. RN H told HDC that she should have followed up on Mrs A's low blood pressure and fever from the previous day, as noted by RN C, but was busy with another resident who had had a fall the same morning, so did not have time to follow up on Mrs A aside from putting a dressing on her pressure injury and carrying out regular visual checks throughout the night. RN H stated that she encouraged Mrs A to drink, and that Mrs A did not appear flushed or feverish; however, RN H did not document this or take any observations, and further stated that Mrs A "appeared to be just the same as usual". RN H handed over the concern about the ankle pressure injury to the morning nurse, RN C.

31. RN C told HDC that when she went to see Mrs A with RN H, she noticed the redness on Mrs A's left leg on the side opposite the pressure injury. RN C stated that as the redness on the left leg was not prominent or near the pressure injury, she thought that the redness was a heat rash, but did not document this. At 9am, RN C created an incident report and completed a wound assessment form, a wound management plan, and a short-term care plan, which recorded pressure and wound management interventions.[16] Pressure management interventions included the need to put Mrs A on her right side when settled in bed, change her mattress to an air mattress, and elevate her feet with a pillow for better circulation.

32. Under the "immediate action taken" section of the incident report, RN C recorded that she had elevated Mrs A's feet. RN C documented in the progress notes: "[Pressure injury] on L ankle. Dressed as per [treatment] plan. Please observe pressure management. Keep pressure off the area." RN C told HDC that she "took all the necessary steps without any delay" for the pressure injury.

33. In response to my provisional opinion, RN C stated: "Apart from [the pressure injury], [Mrs A] appeared to be more awake and alert and [had] been drinking better than on the previous day."

34. There is no documented evidence to show that planned pressure interventions were carried out following this.

[14] A progress note from the previous shift states: "[Mrs A] has got water and we keep encouraging her to drink."

[15] Although as already noted at paragraph 19, on Day 1 a GP commenced Mrs A on zopiclone, which helped her to sleep better.

[16] Pressure management interventions stated to put Mrs A on her right side when settled in bed, change her mattress to an air mattress, and elevate her feet with a pillow for better circulation. Wound management interventions stated: "[S]aline wash, iodosorb + inadine (for autolytic deb[r]idement), allevyn as secondary dressing, cavilon on surroundings, monitor daily to check if the wound dressing is soiled. Otherwise, change every 2 to 3 days. Evaluate wound and wound products used 7/7, swab wound and send to lab if needed."

35. At 2pm, RN C documented:

> "General deterioration … fluids encouraged. On sip a cup [with] straw [with] good result. [Pressure injury on left] ankle. Dressed as per [treatment] plan. Please observe pressure management."

36. RN C did not take any observations as a follow-up to her concerns from the previous morning. She told HDC:

> "As the only RN during the morning shift at the rest home, I prioritized my patients as there were more sicker residents who needed my attention during that shift. I did not take vital signs for [Mrs A] during my shift, as there was nothing alarming or unusual for her during my shift nor did the caregivers report any concerns that prompted me to take her vital signs."

37. In relation to the meaning of the "general deterioration", RN C told HDC:

> "There had been a consistent decline in [Mrs A's] condition for the past few months. Considering her age and comorbidities, including a further CVA in [2017], I recorded the decline in her condition as *general deterioration*. By this, I did not mean that her condition had deteriorated in the last couple of days."

38. The afternoon nurse on duty that day, RN G, told HDC:

> "[Mrs A] had a decline in general health over the last several weeks and generally looked unwell/'worn out'. General slowing down — speech/mobility/ability to perform ADLs[17]/Cognition."

39. RN G told HDC that she did not take any observations or follow up on RN C's written and verbal concerns regarding Mrs A's left leg as she felt that Mrs A was "as usual", and she was having a busy duty. RN G did not implement the short-term care plan for Mrs A's pressure injury or record any progress notes during her shift, nor were any notes documented by caregivers.

40. Following these events, Mountain View stated in a letter to RN G that, as a registered nurse, she was responsible for the standard of care to Mrs A during her shift, which included performing a full assessment. The letter noted that RN G's "job was to follow up concerns of the previous 24 hours[18] and record those assessments in the progress notes". Mountain View further stated that during its internal investigation, RN G indicated that she thought that Mrs A had "been looking unwell for a few months now", but noted that RN G did not raise this concern with the Charge Nurse, or document it in the notes.

[17] Activities of daily living.

[18] For example, noted pressure injury concerns and the "general deterioration" documented by RN C earlier that day.

Day 7

41. During her night shift from 11pm on Day 6 to 7am on Day 7, RN I recorded that Mrs A had been unwell and restless. RN I took regular observations and noted a high fever of between 38–39.4°C, which she attempted to reduce by implementing cooling measures including a sponge bath, and giving paracetamol at 1am and 5.30am. RN I's final observations were taken at 5am on Day 7, when Mrs A's temperature was 38.4°C. RN I documented: "[Left] lower leg inflamed — reddened warm tissue evident … Affected area outlined with marker pen."

42. RN C was on duty for the morning shift. She told HDC that RN I handed over the issues of Mrs A's fever and worsened redness on her left leg.

43. In relation to the care she provided that morning, RN C told HDC:

> "Because of the elevated temperature noted by the night staff (38.4°C at 5am on [Day 7]), I would have checked [Mrs A's] temperature at the beginning of my shift approximately at 0730hrs, but unfortunately, I did not record this. … I checked [Mrs A] and she was settled and sleeping, the redness in her leg had not changed from the marking by the night RN so I decided to let her rest and continue to observe."

44. RN C also stated that she asked the caregivers who were looking after Mrs A to leave a female urinal in place to collect a urine specimen. RN C told HDC that after her medication rounds finished at 9.30am, she checked on Mrs A and attempted to give her fluids, and noticed that the leg redness had spread over the area marked by RN I. RN C stated that she would have checked Mrs A's temperature again prior to giving her another dose of paracetamol at 10am. However, the action of checking Mrs A's temperature again and the attempt to give her fluids were not documented in the progress notes.

45. At 10.30am, RN C carried out further observations and noted that Mrs A's fever was over 39°C. RN C told HDC that she then sought help from another nurse regarding Mrs A's condition, and then discussed with RN D the need to notify the doctor, as she suspected that Mrs A had cellulitis.

46. RN D told HDC:

> "On the morning of [Day 7] I attended to urgent work in my office until 1030am, although was available to be interrupted for urgent matters. As is my usual practice, I went to the nurse's office after this to informally enquire about the residents. [RN C and another nurse] were looking at photographs of [Mrs A's] leg. I viewed the photographs and vital sign observations that had been taken and advised the nurses to contact the General Practitioner and send [Mrs A] to hospital.[19] During working hours, the local general practitioners like to be consulted before their patient is sent to hospital."

[19] RN D told HDC that registered nurses are not required to seek the approval of the Charge Nurse or Facility Manager to call an ambulance and/or seek medical attention if a clinical situation requires such a decision.

47. RN C stated:

> "Prior to sending [Mrs A] to hospital, we had to request the GP to see her first. This is because, in the past, whenever we tried to send residents to the hospital during business hours, the hospital always questioned us whether the patient had been seen by the GP."

48. In relation to the care she provided that day, RN C stated that she wishes she could have carried out the hourly monitoring that Mrs A's condition required. RN C told HDC:

> "[F]ollowing the observations, and discussing [Mrs A's] condition with the other RN and the manager, I suspected [Mrs A's] condition to be either cellulitis or UTI.[20] At that stage, my priority was to inform the GP and seek advice regarding treatment for [Mrs A]. I could not have done hourly observations while juggling to do the above as well as looking after the other residents. I did what I could possibly do under the circumstances."

49. At 11.18am, RN C sent a facsimile (fax) marked "For your review"[21] to the medical centre for the attention of Mrs A's regular GP, noting that Mrs A had deteriorated over the weekend and had developed a rash on her lower leg two days previously, which had spread up to below her knee and was warm to the touch, and that a photograph of the rash had been emailed to the practice nurses for "[q]uery Cellulitis?". The fax further noted that Mrs A's daughter wished Mrs A to be sent to hospital if needed.

50. RN C stated that she made several telephone calls to the GP practice to follow up on her request between the time she sent the fax and when a discussion with a GP occurred around 12.30pm.[22] Following discussion with the GP, it was agreed that Mrs A would be sent to the hospital. RN C stated that she then called the ambulance, and, while waiting for it to arrive, she recorded that at 2pm Mrs A's temperature was 38.6°C.

51. Mountain View told HDC that the ambulance was delayed because of its priority system. It arrived at 2.15pm and transferred Mrs A to the public hospital.

Further information

52. Mountain View acknowledged that it should have arranged for an interRAI re-assessment of Mrs A's condition and care following her CVA in October 2017 in order to assist with updating her long-term care plan, and acknowledged that the interRAI assessment completed before Mrs A's CVA and the care plans in place did not completely reflect the deterioration noted in the progress notes.

[20] Urinary tract infection.
[21] There was also an option to mark the fax as "urgent".
[22] Mountain View stated that Mrs A's regular GP was not working that day, and that the discussion with the GP occurred at 12.38pm.

53. In relation to Mrs A's condition over the weeks preceding these events, Mountain View told HDC: "Prior to [Day 1], [Mrs A] wasn't consistently deteriorating … There were times that she was eating and drinking well and having a good sleep."

54. Mountain View stated that none of its registered nurses had any recollection of being told that Mrs A's daughter could be contacted any time day or night. However, it acknowledged that RN C should have informed Ms B that her mother's condition had deteriorated on the morning of Day 6, including that a pressure injury had been noted and treatment commenced.

55. Mountain View's internal investigation into the care provided to Mrs A from Day 5 to Day 7 concluded:

> "Carers did not document their concerns in [Mrs A's] progress notes. RNs did not perform thorough assessments in a timely manner. Some RNs did not follow up concerns from the previous shift. Communication between Carers and RNs, RNs with each other, RNs with their Charge Nurse and with [Mrs A's] family was not good enough. In hindsight the Night RN should have sent [Mrs A] to Hospital by ambulance in the early hours of [Day 7] when she was clearly very unwell. Failing that the AM RN should have prioritized sending [Mrs A] to Hospital prior to beginning her usual duties that day."

56. RN C told HDC:

> "Until [Day 7], I had no reason to suspect that [Mrs A] was seriously unwell or any different from the previous months for me to consider commencing any specialized observation charts … Her dietary and fluid intake had been varied since the CVA in [2017], and this was not a change from the previous few days; Her mobility had also declined after the CVA as mentioned, and this was not a change from the previous few days; Her behavior was also no different in the last few days, compared to that in the last few months."

57. RN C acknowledged that she could have made more detailed documentation in Mrs A's progress notes, and further stated:

> "On reflection, and considering the delays that were caused beyond my control in sending [Mrs A] to the hospital, I would now consider seeking a medical review with the GP at the earliest rather than waiting to complete the observations and tests. … I have also learnt that good documentation is vital for continuity of care, and I have tried to be more specific with my documentation since this incident."

Relevant Mountain View policies

58. Mountain View has not provided any specific policy relating to seeking clinical review. However, the "Job Description — Registered Nurse" states in relation to resident care:

> "Weekend leadership is required. The RN is expected to make professional and safe assessments of requirements for residents to send to hospital [and] monitors changes in health status and responds accordingly."

59. In relation to the prevention and management of pressure injuries, the policy "Pressure injury Prevention and Management" (January 2018) states:

> "Pressure area injuries can develop quickly so it is vital that care staff are vigilant in identifying potential pressure areas and reporting them to the RN immediately in order to minimize risk."

60. Further, the policy states:

> "Report and document all relevant findings, in the care plan and in the Residents Progress Notes. Think about escalating the intervention when care at the bedside is ineffective … All incidents of pressure injuries or potential pressure injuries are to be reported to [RN C]. An incident form should be completed to ensure a comprehensive risk review to be undertaken of the residents care."

61. In relation to the process for transferring a patient to hospital when a resident requires further care, the policy "Transition, Exit, Discharge or Transfer Policy" (January 2018) states: "In Emergency or Acute Situations … The Doctor will be consulted."

62. In relation to documentation, the policy "Assessment Procedure" (January 2018) states:

> "[Staff must ensure linkages when the] person undertaking the assessment is different than the person carrying out the care. Comprehensive verbal and written handovers take place between registered/special duties staff and carers between shifts, which may include the Handover Summary, Progress Notes, observations charts and admission, short term and long term care plans."

Changes made and actions taken since these events

63. Mountain View stated that it implemented the following changes as a result of this incident:

1) A senior caregiver has been assigned on each shift to be responsible for ensuring that all the assigned residents' progress notes and intentional rounding[23] tasks are completed.
2) A caregiver handover sheet has been started and is completed by the senior caregiver on morning and afternoon shifts. This handover is reviewed by the duty registered nurse.

[23] Intentional rounding involves nurses checking on a patient at regular intervals to assess and manage care.

3) The care of Mrs A was discussed at a registered nurses meeting. The nurses were asked to undertake a one-on-one handover and visit any sick/palliative residents together to discuss treatment plans.

4) Registered nurses were reminded to report to the Charge Nurse or Facility Manager for all serious issues when needing advice, and to send residents to hospital by ambulance if they feel that is the best option.

5) A training exercise for all registered nurses involved in Mrs A's care was held. Each of the nurses reflected on their practice and completed questions on how they could have improved their care of Mrs A.

6) RN C completed further nursing postgraduate certification courses in "Advanced assessment and clinical reasoning" and "Self-management for people living with long term conditions". RN C has also completed further training, including on the issues of identifying at-risk residents, and decisions around hospitalisation, communication, and wound management.

Responses to provisional opinion

64. Ms B, The Kawerau Social Services Trust Board (trading as Mountain View), and RN C were given the opportunity to respond to relevant sections of my provisional opinion.

65. In response to the "information gathered" section of the provisional report, Ms B said that there is overwhelming evidence of breaches of the Code of Health and Disability Services Consumers' Rights (the Code). She stated: "[Mountain View's] practitioners failed to take reasonable care and were well below the accepted professional standards."

66. The Kawerau Social Services Trust Board said that it had no comment to make on the provisional opinion, and apologised for the distress caused to Mrs A and her whānau for omissions in care.

67. RN C's comments have been incorporated into the report where relevant. She reiterated that as a result of these events:

> "I have learnt that even though how busy and long the day I had it is important that I make a detailed documentation of overall care that I provide for each patient and am applying this in my practice."

Relevant standards

68. 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."

69. Principle 4.1 of the New Zealand Nursing Code of Conduct (June 2012) states that a Registered Nurse should:

> "Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care."

Opinion: The Kawerau Social Services Trust Board — breach

Introduction

70. The Kawerau Social Services Trust Board had a duty to provide Mrs A services with reasonable care and skill. This included responsibility for the actions of its staff.

71. In this case there appears to have been a failure in clinical reasoning, care coordination, and communication across shifts. The care plans were not used as a living document to drive patient-centric care across shifts, and further the lack of observation charts meant that the ability of nursing staff to deliver continuity of care, in consideration of Mrs A's changing needs across shifts, was constrained. While there were individual failings in the care provided to Mrs A (outlined in more detail below), in my view this case illustrates a pattern of concerning issues for which Mountain View bears responsibility.

Lack of monitoring and observations

72. On the morning of Day 5, RN C took observations and asked for monitoring of Mrs A's condition to continue, as she was dehydrated, feverish, and hypotensive.[24] Despite this, RN F, RN H, RN G, and RN C did not take any observations in the subsequent shifts. The next observations were completed only in the early hours of Day 7 by RN I, who noted that Mrs A had a high fever exceeding 38°C and an inflamed left leg.

[24] Having low blood pressure.

73. Also on Day 5, two caregivers noticed redness on Mrs A's left leg, although only one of the caregivers documented concerns. RN F, who was on the afternoon shift that day, did not carry out a full assessment, as he assumed that the redness was a heat rash owing to the hot weather. RN C stated that on Day 6 she also believed that the redness was a heat rash, as it was not prominent or close to the pressure injury on Mrs A's ankle that had been noted earlier that morning by RN H. Neither RN C nor RN F documented their assessments or rationale.

74. My in-house aged-care advisor, RN Hilda Johnson-Bogaerts, was critical that staff did not continue to monitor Mrs A's condition from the afternoon of Day 5, and was very concerned that the redness on Mrs A's leg reported by the caregiver was not followed up the same day. RN Johnson-Bogaerts further advised that Mrs A's condition on the morning of Day 7 warranted hourly follow-up, and was critical that that did not occur. RN Johnson-Bogaerts said that good practice would have required staff to continue monitoring Mrs A closely and assess whether urgent medical referral was indicated. RN Johnson-Bogaerts advised that these failures were a moderate departure from accepted practice.

75. I am critical that a number of Mountain View nursing staff failed in their duty to monitor and take adequate observations following the noted concerns of Day 5 when Mrs A required closer attention. Aside from RN C's entry in the progress notes on the morning of Day 5, there appears to have been poor handover of Mrs A's condition between shifts. I also accept my expert's advice that Mrs A should have received hourly monitoring when she developed a high fever of over 38°C on the morning of Day 7, an increase from 37.7°C on Day 5. I am critical that Mrs A was not monitored adequately, and that this failure delayed the treatment she required. As set out in Principle 4.1 of the New Zealand Nursing Code of Conduct, undertaking adequate monitoring of a resident's health status and responding appropriately is a fundamental nursing skill. In my view, the failure of staff to undertake adequate monitoring demonstrates a lack of critical thinking. If appropriate monitoring had taken place, it is likely that more timely and appropriate care to address the high fever and Mrs A's other underlying problems would have occurred. I am also critical of the instances in which nursing staff failed to document their assessments and concerns.

Pressure injury

76. On Day 6 at 5am, RN H recorded that Mrs A had a pressure area on her left ankle. RN H did not perform any observations because she had no concerns and felt that Mrs A "appeared to be just the same as usual", and she handed over to RN C regarding the pressure injury. RN C recorded the injury in an incident report, a wound assessment form, a wound management plan, and a short-term care plan, which noted pressure and wound management interventions.

77. RN Johnson-Bogaerts advised that the interventions noted in the care plans for management of Mrs A's pressure injury were not implemented with the urgency the situation required, and should have been implemented earlier. She noted that while there is documentation to show that wound care was provided, there is no documentation of

the pressure-relief mattress having been put in Mrs A's bed, or the implementation of any other pressure-relief interventions. RN Johnson-Bogaerts advised:

> "When finding a pressure injury, it is good practice to implement pressure relief intervention such as a pressure relief mattress as soon as possible and during the same shift. It is pressure that is the cause of the development and deterioration of such a wound."

78. RN H should have recorded a detailed management plan of Mrs A's pressure injury soon after she noticed it at 5am on Day 6. However, I note that she did hand over this concern to RN C, who, in accordance with the policy "Pressure injury Prevention and Management" (January 2018), completed the necessary pressure/wound management and care plan forms that day. Mrs A's feet were elevated immediately as per the pressure management plan, but there is no evidence that this was continued or that other pressure interventions were implemented in subsequent shifts. The afternoon shift nurse who took over from RN C on Day 6, RN G, also did not follow up on Mrs A or record any progress notes. For this reason, I accept my expert's advice that the implementation of care for Mrs A's pressure injury was unnecessarily delayed, and that a key component of the pressure-relief intervention strategy — the placement of a pressure-relief mattress — was not implemented.

Other comment

79. I note that whilst Mountain View stated that Mrs A's condition had not been deteriorating consistently prior to late January 2018, conversely RN G and RN C have stated that there had been a general deterioration in Mrs A's condition in the weeks/months leading up to these events.[25] This apparent discrepancy suggests that there may have been inconsistent assessment and monitoring of Mrs A's state of health, in addition to inadequate staff communication about her general condition around this time. Without a consistent understanding about her condition between all staff, delivery of Mrs A's care would have been affected adversely.

Assessments and care plans

80. Mrs A had a CVA in 2017, and since that time her dietary and fluid intake had been varied, and her mobility had declined. The NZHDSS require that rest homes ensure that consumers receive timely and appropriate services in order to meet their needs, and that assessment is provided as required within time frames that meet consumers' needs safely. The DHB's contract with Mountain View also required it to carry out an interRAI re-assessment for Mrs A if it was identified that there had been a significant change in her level of need. RN E, as Charge Nurse, did not arrange for Mrs A to undergo a further interRAI assessment following Mrs A's CVA, and Mountain View acknowledged that this should have been carried out.

[25] See paragraphs 35–38.

81. RN Johnson-Bogaerts noted that the interRAI assessment from 2017 used to create a general picture of Mrs A's health and condition pre-dated Mrs A's deterioration owing to the CVA. RN Johnson-Bogaerts advised that an interRAI re-assessment following the significant change in Mrs A's health would have helped to guide appropriate long-term care planning, and should have been updated to reflect Mrs A's situation more accurately.

82. RN Johnson-Bogaerts said that the failure to carry out a post-CVA interRAI assessment and maintain up-to-date care plans was a mild departure from accepted practice. I accept this advice that a further interRAI assessment would have provided staff with a more accurate picture of Mrs A's condition following her CVA, and allowed for the implementation of appropriate long-term care planning and better provision of overall care. Mountain View's contract with the DHB obligated it to reassess Mrs A with interRAI if it identified a significant change in her level of need, and it had delegated responsibility to RN E for ensuring that this occurred. However, the fact that RN E did not do this is only one example of a pattern of omissions of care and assessments by Mountain View's staff, and I am therefore critical of Mountain View that it failed to meet its duty of care to Mrs A in this respect.

83. Owing to the above, Mountain View also failed to meet NZDHSS requirements in relation to providing timely and appropriate assessment so as to meet Mrs A's increased needs following her CVA.

84. RN Johnson-Bogaerts further advised that Mrs A's care plans did not completely reflect her deteriorating condition, and could have been updated to reflect her situation better. I accept this advice.

Conclusion

85. In this case, there was a pattern of failings involving multiple Mountain View staff:

1) Nursing staff failed to follow up on documented concerns by carrying out assessments and observations, and failed to document their concerns or assessments of Mrs A's condition.

2) Mrs A's condition on the morning of Day 7 warranted hourly follow-up, but this did not occur.

3) There was a failure to provide care for Mrs A's pressure injury with the urgency it required.

4) Mrs A did not receive an interRAI re-assessment following her CVA-related deterioration, and her care plans were not up to date.

86. This had an overall detrimental effect on the care Mrs A received. In my view, it was the responsibility of The Kawerau Social Services Trust to have in place adequate systems in order to ensure that Mrs A received appropriate care. I consider that the failures by multiple Mountain View staff, as set out above, demonstrate a pattern of suboptimal care that is directly attributable to The Kawerau Social Services Trust, as the service operator.

Accordingly, I find that The Kawerau Social Services Trust Board failed to provide Mrs A with an appropriate standard of care, and breached Right 4(1) of the Code.[26]

Other comment

Communication with family

87. Ms B complained that Mountain View staff did not contact her when needed as per the agreement that she could be contacted about her mother any time day or night. Mountain View has accepted that it should have communicated with Ms B sooner on the morning of Day 6 about her mother's deteriorating condition and the pressure wound, and I agree that this would have been appropriate in the circumstances.

Opinion: RN C — adverse comment

88. RN C was the registered nurse on duty responsible for Mrs A's care on the morning shifts of Days 5, 6, and 7.

89. I am mindful that RN C was not the only nurse charged with the care of Mrs A during the time period in question, and that there was a pattern of failings across multiple staff that contributed to the unsatisfactory care Mrs A experienced, as discussed above. RN C did, however, have the most contact with Mrs A of all nursing staff, and therefore had more opportunities than most to ensure that appropriate follow-up care was provided. RN C was also responsible for the management of wounds and pressure injuries.

90. Mountain View's investigation report states that RN C had been informed on the morning of Day 5 that Mrs A was delirious and had redness on her left leg; however, RN C disputes this. Given that there is no contemporaneous record of RN C having been informed of Mrs A's leg redness at this time, and the differing recollections, I find that this information was not conveyed to her clearly. In any case, it is important that caregivers document their communications with nursing staff adequately at all times to ensure appropriate follow-up and accountability.

91. On the morning of Day 5, RN C took Mrs A's observations and noted that ongoing monitoring was required, but she did not undertake additional observations herself until the morning of Day 7. RN C stated that on that day at 7.30am she would have checked Mrs A's temperature and leg redness, and that later at 10am she noticed that the redness on Mrs A's leg had spread, and she checked Mrs A's temperature again before administering paracetamol. RN C did not document the temperatures or all of the actions she took in the progress notes. RN C then discussed Mrs A's condition with RN D, and subsequently a GP, before she contacted the ambulance to transfer Mrs A to the public hospital.

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

92. As noted above, RN Johnson-Bogaerts advised that Mrs A's condition warranted hourly follow-up observations on the morning of Day 7, and felt that RN C departed from accepted practice by not doing so.

93. RN Johnson-Bogaerts considered that RN C's explanation regarding the care she provided would be seen by her peers as sound clinical reasoning, but that it was a mild departure from accepted practice that RN C's reasoning was not documented clearly in the clinical notes.

94. I am critical that RN C did not take any observations on Day 6, despite the fact that the previous day she had recorded the importance of ongoing monitoring. I accept my expert's advice that Mrs A should have received hourly monitoring on the morning of Day 7, and am critical that this did not occur, particularly as RN C, as a senior member of the nursing team with experience with wound and pressure injuries, should have been critically aware of the importance of regular monitoring. However, I note RN C's comment that she felt that it was not possible for her to take hourly observations for Mrs A at that time, as she had to attend to other residents, and her focus was on seeking GP advice for escalation of care. I consider that if RN C felt that she was too busy to take hourly observations when required, she should have delegated this duty to another staff member for more appropriate monitoring of Mrs A's condition while she attempted to escalate concerns. It is also of concern that RN C failed to document all of the care she provided on that morning, and did not record a more detailed account of her overall care in the clinical notes.

95. I note that following her recorded observations at 10.30am on Day 7, RN C appears to have taken appropriate steps to escalate Mrs A's care by contacting the GP practice and subsequently arranging for transfer to hospital. While it seems that contacting the GP was not strictly necessary in order to call for an ambulance, it appears that this was standard practice and expected. It is unfortunate that at such a critical juncture in Mrs A's care there were delays with reaching the medical centre and in ambulance availability; however, in the circumstances, I consider that RN C did what could reasonably have been expected of her, in her role as registered nurse, at this time.

96. RN C accepts that she should have made more detailed documentation in Mrs A's progress notes, and stated that she has learnt from this experience and has taken steps to be more specific with her documentation.

Recommendations

97. I recommend that The Kawerau Social Services Trust Board:

a) Provide a written apology to Mrs A's family. The apology is to be sent to HDC within six weeks of the date of this report.

b) Review and/or develop relevant policies or guidelines to support registered nursing staff in their clinical decision-making, including:

— when to seek clinical review

— managing a deteriorating patient.

The relevant policies and guidelines should be provided to this Office within three months of the date of this report.

c) Within three months of the date of this report, provide details of further improvements it has taken relating to ensuring appropriate monitoring of a sick resident and handover care between shifts.

d) Use an anonymised version of this report as a case study to provide continuing education to nursing staff at Mountain View.

e) Schedule regular and ongoing education sessions for all nursing and caregiving staff on the following topics:

— Short-term care plans

— Monitoring a sick patient

— Use of assessment and monitoring tools

— Handover and documentation.

f) Conduct an audit of up to 20 residents with wound care plans, to ensure that noted interventions for wounds are being implemented without delay or omissions, and report to HDC on the results of the audit within six months of the date of this report.

g) Conduct a review of interRAI assessments and care plans for 20 residents to ensure that they are up to date, and report the results of the review to HDC within six months of the date of this report.

98. I recommend that RN C provide evidence of the further training and qualifications she has completed since these events, within two months of the date of this report.

Follow-up actions

99. A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Kawerau Social Services Trust Board (trading as Mountain View Home and Hospital), will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

100. A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Kawerau Social Services Trust Board (trading as Mountain View Home and Hospital), will be sent to HealthCERT (Ministry of Health) and the DHB, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from in-house aged-care advisor RN Hilda Johnson-Bogaerts:

"1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided to [Mrs A] by Mountain View Rest Home and Hospital. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I was asked to review the documentation and advise whether the care provided to [Mrs A] by Mountain View was reasonable in the circumstances. In particular, I was asked to comment on:

   i. Whether the assessments undertaken by Mountain View staff between [Days 5–7] were adequate/appropriate.

   ii. Whether the monitoring of the pressure area and treatment provided during this time period was reasonable.

   iii. The adequacy of the clinical documentation and handover between staff during this time period.

   iv. The timeliness of contacting an ambulance and transferring [Mrs A] to hospital.

3. Documents reviewed

- Letter of complaint dated […].
- Mountain View's response dated […], including their internal investigation documentation.
- Clinical records from Mountain View covering the relevant period.
- Mountain View's organisational policies relating to clinical care.

4. Background:

[Ms B] and [her sister] raise concerns about the care provided to their late mother, [Mrs A], by Mountain View. On [Day 5], [Mrs A] was unwell with a low grade fever and low blood pressure. Redness was noted on her leg on the PM shift. On [Day 6], a possible pressure area or lesion was noted on her left ankle, and by the night shift, her temperature was very high and the cellulitis was marked.

[Mrs A] was transported via ambulance to [the public hospital] on [Day 7] at approximately 2.15pm. Sadly, she died [a few days later] from sepsis secondary to cellulitis.

5. Review of clinical records

[Mrs A] was [a lady in her seventies] residing since [2016] at Mountain View Rest home and Hospital. She was admitted after a fall secondary to multifactorial deficit and TIA. Her diagnosis included:

- Previous CVA and TIA
- Diabetes Mellitus
- Hypertension
- Atrial Fibrillation — on Warfarin therapy

The last interRAI assessment completed on 4 October 2017 identified:

- some cognitive decline with difficulty expressing herself and significant short term memory loss
- mobilising independently with walking frame — risk of falling
- occasional episodes of incontinence
- intermittent pain, muscle pain mostly R-hip
- overweight (BMI 33)

[In 2018], the caregiver of the afternoon shift documents *'urine has an offensive odour, have informed RN'.*

The days after this show a picture of '*restlessness*' and '*lower back pain*' '*very tense', 'wiggling around', 'grumpy*', '*trying to get out of bed*', '*use of hoist, weakness legs*'. Paracetamol was given however I did not find in the documentation evidence of registered nurse investigation into the possible cause of these symptoms. The offensive odour, restlessness and pain are typical first symptoms of a Urine Tract Infection in older people.

[Mrs A's] clinical notes during [the weeks leading up to these events] show a functional decline with an increased need in assistance. These included the use of hoist for transfers. Intervention for falls prevention were put in place. The clinical notes continue to report on poor dietary intake, restlessness, and unsettled nights.

[A few days later], the same caregiver reports '*Urine still offensive'*.

[Day 1], [Mrs A] was seen by the GP for a routine review. He prescribes Zopiclone to be given regularly now, for insomnia.

[Day 5], the registered nurse on morning duty reports *'… sleepy this morning, poor dietary intake, … Obs taken BP 92/53, O2 95–98%, PR 102, T 37.7 C. Regular paracetamol given, fluids encouraged ? Dehydration, Continue to monitor'.*

The caregiver of the afternoon duty documents that [Mrs A] declined her dinner and she keeps encouraging her to drink. *'Noticed redness on her lower left leg. RN aware of this … RN has informed night shift'.* No further observations were entered in the progress notes or the Observation Chart.

The registered nurse on night duty notes *'very foul smelling urine …, pressure area on L lateral foot, nil other concerns'*. A picture was taken of this lesion.

[Day 6], the registered nurse documents *'general deterioration, sleepy, fluids encouraged, PI injury on left ankle … Please observe pressure management, …*' I did not find any evidence that any observations were taken following on from the previous day's worries or as a result from the statement '*general deterioration*'.

The night nurse notes that [Mrs A] '*has been unwell and restless*'. She takes regular observations and notes a high fever which she attempts to reduce by way of cooling measures and paracetamol however with little result. She also notes *'L lower leg inflamed — reddened warm tissue evident. Appears tender*'. She marks the area with a marker pen. She also notes that when she encourages [Mrs A] to drink that she has difficulty swallowing. She finds she has better results with giving thickened fluids.

[Day 7], the progress notes from the morning duty do not include any entries for that morning. The Observation sheet shows an entry from that morning 10.30am and includes the results of observations taken. [Mrs A's] temperature that morning is documented to be 39°C with an elevated blood pressure. The RN sends a fax to the GP advising the GP of the deterioration and that the family would like her to be sent to hospital. A note confirms that the GP advised for [Mrs A] to be sent to hospital.

The next entry in the Progress Notes read that [Mrs A] was sent to hospital with ambulance in the early afternoon. Transfer documents were completed. Reason for transfer: '*Rashes that spread up to below knee ?Cellulitis and elevated temp*'. The hand-over notes also include '*urine strong and concentrated'*, *'dipstick result positive, urine spec sent to lab in the morning for possible UTI'*.

6. Clinical advice

i. Whether the assessments undertaken by Mountain View staff between [Days 5–7] were adequate/appropriate.

I am concerned about the lack of observations taken in the days leading up to [Day 5]. There was no follow up on the noted observations of foul smelling urine, increased restlessness, the decreased ability to mobilise, and the difficulty drinking. Accepted nursing practice requires for the registered nurse to follow up on such symptoms as soon as possible and check if a medical referral is indicated. There is no evidence that nurses looked for a possible cause of the acute deterioration and restlessness.

The GP reviewed [Mrs A's] condition on [Day 1]. It would appear that the message to the GP was limited to restlessness at night and difficulty sleeping. The GP prescribes medication to aid with sleeping at night.

Following the noted difficulty with drinking good practice requires to start a fluid balance chart so that a picture can be obtained of fluid intake.

Departure from accepted practice — moderate.

I am critical that in the afternoon of [Day 5] [Mrs A's] condition did not continue to be monitored as requested by the nurse in the morning who noted the change in condition. I am very concerned that the redness on her leg reported by the caregiver to the registered nurse was not followed up the same day. This lack of follow up on noted concerns continued until the night nurse on [Day 6] found that [Mrs A] had a high fever and attempted to reduce the fever with little to no result. Good practice would have required the nurse on duty in the afternoon on [Day 5] to continue to observe [Mrs A] closely and assess if an urgent medical referral was indicated. The lack of immediate follow up [when] the caregiver reported redness on her leg where earlier also a pressure injury was found is unacceptable. On the morning of [Day 7] the night nurse takes the last observations of her shift at 5 am. Follow up by the morning duty is very slow and the next observations taken are taken 5 hours later while [Mrs A's] condition warranted an hour to hour follow up.

Departure from accepted practice — significant.

ii. Whether the monitoring of the pressure area and treatment provided during this time period was reasonable.

The nurse who found the pressure injury started the wound treatment and documented her findings. The Progress Notes in the days after this include pressure relief measures implemented on the respective duties. It is however not clear from the documentation that these pressure relief measures continued. I did not find a nursing care plan relating to a pressure injury. Good nursing practice requires the development of a short term care plan or the update of the long term care plan with appropriate pressure relief measures as well as wound care instructions. The nurses did not follow the Pressure Injury Prevention and Management Policy of the organisation.

Deviation from accepted practice — moderate to significant.

iii. The adequacy of the clinical documentation and handover between staff during this time period.

Good nursing practice would have required the commencement of short term care plans and/or the update on the long term care plan. It is good practice to commence observation charts relating to the different health concerns. In this case this would include [Mrs A's] dietary intake, fluid intake, mobility, behavioural changes

(restlessness, sleep). Such observation charts are a good means to focus on issues of concern as well as providing objective results that guide future care planning and/or a medical review.

I am concerned that care plans were not up to date with the changes in [Mrs A's] health and care needs. As a result there was no proper communication between the shifts. Overall care management was lacking.

Deviation from accepted practice — moderate to significant.

iv. The timeliness of contacting an ambulance and transferring [Mrs A] to hospital.

Accepted practice required the nurses to have referred [Mrs A] for a Medical review at the earliest time that the redness of the leg was noted together with a low grade fever and a wound on the same leg i.e. on the afternoon of [Day 5].

On the night of [Day 6] when [Mrs A] was experiencing a high fever together with redness on her leg the situation became more urgent. Good practice required the night nurse to consult immediately with an after hours medical service or the hospital for advice on suspected sepsis which is a life threatening condition.

On the morning of [Day 7] the nurse consults with the GP at 11 am and the ambulance picks [Mrs A] up at 2 pm.

It is my opinion that [Mrs A's] referral for medical review and transfer to hospital was not treated with the urgency it required.

Deviation from accepted practice — moderate.

7. Additional Comment

There seemed to have been a breakdown not only in clinical reasoning by the nurses but also a breakdown in care coordination across the shifts. The lack of use of observation charts and short term care plans for acute health issues means that every shift resident's care is organised as it appears to the nurses at that time. Clearly the care plans were not used as a living document to drive person centric care across the shifts.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor"

RN Johnson-Bogaerts provided the following further expert advice on 13 September 2019:

"Thank you for the request that I provide additional clinical advice after receipt of provider's response dated 11 July 2019 and in relation to the complaint about the care provided by Mountain View Rest Home and Hospital to [Mrs A]. This memo should be read alongside the initial advice provided by me on 28 January 2019. In preparing the advice on this case to the best of my knowledge I have no personal or professional

conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

1. Additional documents reviewed

- Letter of response from the provider to HDC dated 11 July 2019
- Clinical documentation including: Wound assessment Form, Short Term Care Plan, Wound Management Plan, Response to Aged Care Advisor Report, Statements from the on call nurse manager, registered nurses and caregivers, Statement of nurse [RN C].

2. Clinical advice

v. Whether the assessments undertaken by Mountain View staff between [Days 5–7] were adequate/appropriate.

Reasonable explanation was provided in the response from the provider for the noted restlessness, weakness in legs, use of hoist, general deterioration. It was explained that these symptoms were not new and it is reasonable to assume that they related to the CVA in [2017] which had significantly impacted the consumer's function.

I note that the provided interRAI assessment which I used to create a general picture of the consumer's health and condition predated this deterioration. It is not clear if an interRAI re-assessment was completed following the significant change in health and to guide updates of the long term care planning.

I continue to be critical about the monitoring of [Mrs A's] condition following the reported redness on her leg and later the high fever as per my previous advice. Specifically the lack of follow through during the afternoon of [Day 5], and later on [Day 7] when [Mrs A's] condition warranted an hour to hour follow up.

With this new information in mind I note here a moderate departure from accepted practice.

vi. Whether the monitoring of the pressure area and treatment provided during this time period was reasonable.

The provider forwarded in their response the Wound Care Plan and Short Term Care Plan relating to the pressure injury developed the day the pressure injury was found. This nursing care plan was found to be of good quality. However, the noted interventions could have been implemented earlier and with the urgency it required.

With this in mind I note here a mild departure from accepted practice.

vii. The adequacy of the clinical documentation and handover between staff during this time period.

The provider's response provided an explanation relating to the noted concerns regarding restlessness, dietary intake, fluid intake and mobility to be as a result of the

CVA three months earlier. I note that the clinical picture the completed interRAI assessment (completed before her CVA) and the care plans did not completely reflect the deterioration noted in the progress notes and could have been updated to better reflect the consumer's situation.

The statement from registered nurse [RN C] includes a detailed account of her clinical reasoning and actions taken. The account provided by the registered nurse would be seen by my peers as sound clinical reasoning. I have some concerns that this account could have been better documented in the Progress Notes.

With this in mind I note here a mild departure from accepted practice.

viii. The timeliness of contacting an ambulance and transferring [Mrs A] to hospital.

The statement from registered nurse [RN C] included a detailed account of her clinical reasoning and actions taken on [Day 7]. This included a discussion with a colleague and the Manager that morning. They decided to contact the GP first before referring to the hospital which unfortunately caused some delay. The ambulance was called immediately after the instruction from GP and unfortunately availability of the ambulance caused a further delay in transferring [Mrs A] to hospital. The account provided would be seen by my peers in these circumstances as accepted nursing practice.

Departure nil.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor"

RN Johnson-Bogaerts provided the following further expert advice on 3 March 2020:

"I reviewed the documentation — short term care plans and the nurses' statements of the relevant days. Thanks for providing the relevant links.

The planned interventions documented in the short term care plan relating to the pressure injury included pressure relief interventions including '*change mattress to an air mattress'*. The progress notes as well as the nurses' statements speak of the wound care provided only — I did not find documentation of the pressure relief mattress being put in the consumer's bed or any other pressure relief intervention implemented. When finding a pressure injury, it is good practice to implement pressure relief intervention such as a pressure relief mattress as soon as possible and during the same shift. It is pressure that is the cause of the development and deterioration of such a wound.

Kind regards

Hilda Johnson-Bogaerts
Clinical Advisor — Aged Care"