HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00015)

Complaint and investigation

1. Mr A (dec) was a resident in a care home (operated by Bupa Care Services NZ Ltd). Mr A's friend, Ms B, complained to the Health and Disability Commissioner (HDC) about the care provided at the care home. The following issue was identified for investigation:

- *Whether Bupa Care Services NZ Ltd provided [Mr A] with an appropriate standard of care in 2020.*

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

3. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's executor
Care home	Provider
RN C	Provider/registered nurse (RN)

4. In-house clinical advice was obtained from RN Hilda Johnson-Bogaerts (Appendix A).

Introduction

5. Mr A was aged 88 years. His medical history included metastatic adenocarcinoma (cancer) of the lung, persistent malignant pleural effusion (fluid around the lungs) requiring an indwelling pleural catheter (IPC), sepsis that was secondary to an IPC infection, anaemia (lack of red cells or haemoglobin in the blood) that was treated in hospital in September 2020, atrial fibrillation (irregular heartbeat), spinal stenosis (narrowing of the spinal canal) resulting in lower limb weakness, hypertension (high blood pressure), and a previous cerebrovascular accident (CVA) (a stroke). He needed support and assistance for all aspects of personal care, and full assistance with transferring and mobilising.

6. Mr A had been being cared for at home, by his friend and primary caregiver, Ms B, supported by a public hospital's inpatient palliative care services during acute admissions, and the region's community hospice services and a community organisation when he was at home.

He had an acute admission to the public hospital from 7 to 16 Month1[1] 2020 for treatment of delirium and sepsis as the result of an infection in his IPC.

7. Mr A had appointed Ms B as his Enduring Power of Attorney for personal care and welfare (EPOA), but the EPOA had not been activated, and he retained the capacity to make decisions for himself.

Care home

8. The care home is operated by Bupa Care Services NZ Ltd (Bupa). Bupa told HDC that the care home provided dementia and hospital (medical and geriatric) care, usually under the Aged Residential Hospital Specialised Services Agreement (ARHSS).

9. Bupa told HDC that the care home provides care for residents who are at the end stage of their life. This is done in consultation and collaboration with the resident's general practitioner (GP), the public hospital's palliative care services, the community organisation's clinicians, family, and the residents themselves. Bupa said that when a resident is entering a Bupa care home for palliative or end stage of life support, often those services have already been involved in the resident's care and had previously discussed care options and preferences with the resident and their family. These would be documented in an end-of-life care plan and are provided to the care home prior to admission. However, as discussed below, prior to Mr A's admission, the care home received no documentation that reflected his end-of-life care preferences.

10. At the time of these events, Ms D and RN E were senior staff members in the care home.

Ms B's concerns

11. Ms B had several concerns regarding the care home's care of Mr A, including the following:

- The care home failed to provide Mr A with specialist equipment to respond to his personal preferences. Ms B stated that the care home failed to provide bed rails and sensor mats, which rendered Mr A vulnerable to falls and serious injury.
- The care home failed to provide a pressure-relieving mattress and booties, resulting in pressure injuries, and Mr A was provided with a rusty bed cradle that pressed against his legs, causing pain.
- The care home staff were very slow to respond to Mr A's call bell, and the water and call bell were placed out of Mr A's reach.
- The care home failed to provide Mr A with basic medical care. In addition, a fungal infection in Mr A's finger was left untreated.
- The care home failed to provide adequate end-of-life care to Mr A, such as eye and mouth care.
- Morphine was administered orally when there was a subcutaneous (under the skin) line in situ.

[1] Months have been removed to protect privacy.

- Mr A was often left unattended while in a semi-conscious actively dying state.
- The care home had significant staff shortages at the time Mr A was a resident, which impacted on the care provision.
- The care home failed to respond to her numerous complaints about Mr A's care.
- The care home told Ms B that she could not remove Mr A from the care home despite his pleas to be discharged.

Respite care

12. Mr A was admitted to the care home to receive hospital-level respite care from 8 Month2 2020 until 22 Month2 2020. Ms B told HDC that on 8 Month2 2020 Mr A travelled to the care home by ambulance, and she followed by car. She said that the ambulance had been pre-arranged by the community organisation when it arranged the respite care 2–3 days prior to admission.

13. Bupa told HDC that its pre-admission process includes receiving clinical information from external referrers relating to the care requirements of the consumer prior to admission. Based on this information, suitability of the prospective resident for admission to the care home is determined, and, if suitable, the admission is agreed and planned. If agreed, the prospective resident and/or next of kin receives a copy of the admission agreement, which outlines all aspects of care and is required to be signed before the commencement of the stay at the care home.

14. Bupa said that Mr A's admission did not follow Bupa's usual pre-admission process because Mr A and Ms B presented at the care home on 8 Month2 2020 without the care home having received clinical information or a formal referral from external assessors, and without its pre-admission acceptance. Bupa stated that the nurse on duty that day, RN C, proceeded with the admission because the alternative was to send Mr A back home alone or to hospital because Ms B was going away for personal reasons.

15. Bupa told HDC that previously Ms D had received a phone call from a referrer asking about respite care, but as there were no respite beds available at the care home at the time of enquiry, it was agreed with the referrer that the consumer should contact the care home directly to arrange respite care, but that did not happen. Bupa said that Ms D did not document this respite request or take the consumer's name or the referrer's name or agency or any information about the potential resident, and therefore no admission folder was prepared for Mr A's arrival.

16. Ms B told HDC that the admission had been arranged by the palliative care team, and she does not recall being asked to contact the care home directly to arrange respite care, as she believed that this had already been confirmed, and that Mr A was expected on 8 Month2 2020. Ms B told HDC that there was no information about Mr A's care needs or clinical history available to care home staff on arrival, and his medication was withheld from him as it did not come with a prescription.

17. A fax dated 6 Month2 2020 sent from the community organisation to a district nurse organisation advised that Mr A would be admitted to respite care at the care home on Thursday 8 Month2 at 10am and requested that the district nurses visit Mr A at the care home to continue with his IPC care while he was there.

18. Bupa stated:

> 'We acknowledge that both [Mr A] and [Ms B] were under the impression that the respite admission had been arranged and agreed upon, however this was not the case.'

19. Bupa said that in such a situation, the receiving team member would escalate the issue to the most senior person on site at the time. If the senior staff were on site, they would be contacted for advice. However, Bupa acknowledged that at the time, RN C did not escalate the situation to obtain further support and consideration but noted that this was in part due to Ms B informing the team that she was going away, and that Mr A had come from home, where she was his primary support and caregiver.

20. Bupa said that on 8 Month2 2020 RN E was absent because she was unwell. On 9 Month2 2020 when RN E returned to work and discovered that Mr A had arrived at the care home, she immediately requested the care documentation from the community organisation, which Mr A and Ms B had identified as being the referrer. This included a request for care requirements, the public hospital's Discharge Summary (dated 16 September 2020), and a confirmation of respite care from a needs assessment service coordination (NASC) authority. Bupa said that subsequently written confirmation was received dated 12 Month2 2020.

21. Ms B told HDC that when Mr A arrived, there were sticky labels with his name and details, but the labels incorrectly noted him as a permanent resident rather than a respite resident. Ms B stated that RN C told her that the senior staff member was away and had not left Mr A's notes and information for her. Ms B stated that 'the admission was a shambles'. In response, Bupa reiterated that Mr A's admission to the care home had not been confirmed, and no documentation was available as none had been received. Bupa said that no clinical folder or preparation had been completed and noted that the printing of resident labels is done on a template and is very easy and quick to populate and print.

22. On 8 Month2 2020 Ms B, as EPOA, signed the consent forms on behalf of Mr A despite the EPOA not having been activated.

23. Bupa stated that as an admission agreement had not been returned prior to admission, the care home administrator approached Ms B to sign a copy of the admission agreement. Bupa said:

> 'We note, that given [Mr A] was competent and had no activated EPOA in place, staff should have approached him in the first instance, but staff felt that [Ms B] asserted herself as the primary contact to make these decisions on [Mr A's] behalf.'

24. Bupa said that Ms B refused to sign the admission agreement at the time as there was some discussion as to the admission type — whether it was a permanent admission or short stay (respite). However, once it had been confirmed that Mr A was being admitted for respite care, Ms B continued to refuse to sign the admission agreement. Bupa stated that subsequently when Mr A was transferred to permanent admission, Ms B was again asked to sign the admission agreement, but throughout the period Mr A resided at the care home she refused do so.

Admission documentation

25. Bupa told HDC that the admission process and documentation completed by the nursing staff on 8 Month2 2020 followed the process and documentation for short stays, which included the completion of shortened assessments and care planning for immediate need, documented in Bupa's Admission Assessment Booklet. However, RN C did not complete all assessments as indicated in the booklet.

26. The mobility part of the Admission Assessment Booklet noted that Mr A was dependent with his mobility and transfers, and that he would use a 'lazy boy/wheelchair, needs enabler'. The Falls Risk Assessment was only partly completed and concluded that he was at low risk of falling despite having a documented foot drop, vision impairment, low functional status, and low appetite. A Transfer Plan was completed to guide staff on how to support Mr A with transfers, but the plan gave limited information about the assistance he needed to mobilise. For mobility in bed, RN C noted '1x assist' only. The section relating to mobility walking aids/chairs, etc includes that Mr A would use a frame for short distances, but it does not mention any instructions for staff or for the use of a wheelchair and recliner chair (although these were mentioned in the assessment document).

27. Ms B requested that Mr A be provided with bed sides for safety, as he had at home. However, the care home provided Mr A with a bed lever instead. Bupa stated that this was a piece of equipment with a metal loop that extends up the side of the mattress to assist the person to move or change position. Bupa said that in aged care, a bed lever is preferred over bedsides, which are seen as a restraint and discouraged as part of restraint minimisation goals, as well as for safety reasons.

28. The mobility plan does not include the bed lever or whether Mr A was able to use the bed lever to mobilise or turn himself in bed. Furthermore, the mobility plan was not updated when his needs for assistance changed over time.

29. The initial skin assessment included in the Admission Assessment Booklet was not completed despite the progress notes stating that Mr A '[h]ad broken skin on sacrum but already healed' and 'positioning chart commenced to prevent skin breakdown'. The Pain assessment part of the Admission Assessment Booklet included that Mr A would experience pain 'on his knees sometimes', but the full pain assessment form was not completed. The admission notes do not include Mr A's blood pressure as part of the baseline vital signs taken.

30. Ms B told Bupa that she was Mr A's EPOA. However, there is no copy of the EPOA documentation or any evidence in Mr A's records that the EPOA had been activated.

31. The care home did not complete an interRAI assessment. Bupa stated that this was because there is no requirement to complete an interRAI assessment for admission of respite residents.

Removal of urinary catheter

32. Mr A had an indwelling urinary catheter (IDC) in place on his admission to the care home on 8 Month2 2020. Ms B stated that care home staff refused to remove the IDC when Mr A was in pain.

33. Documentation in the progress notes on 9 Month2 2020 states that Mr A complained of penile pain, and RN C made an assessment, including a pain score of 10/10 and vital sign observations (temperature, blood pressure, and pulse). Mr A was administered paracetamol and morphine elixir. Bupa stated that the assessment was to provide an insight into complications such as ongoing pain, retention, or early signs of infection.

34. Bupa stated that although Ms B requested that the nurse remove Mr A's IDC, with no activated EPOA in place and a lack of clinical information prior to admission, staff needed to seek a review prior to any decision-making about the potential removal of Mr A's IDC.

35. Bupa said that the care home staff attempted to contact Mr A's GP to identify the clinical reason for the catheter, and to provide guidance on appropriate steps for Mr A's ongoing care, including the possibility of removing the catheter. The GP did not reply, so the nurse then contacted a senior staff member, who sought clarification from Ms B of the reason Mr A had the IDC. Bupa said that Ms B stated that the IDC was in place for comfort and to support care provided for elimination at home. The senior staff member asked that the IDC be removed, with the understanding that they would continue to monitor Mr A's condition and report any changes or concerns to the GP.

36. RN C recorded in the progress notes that the ICD had been removed at Mr A's request, and his pain had been relieved on removal. No further complaints of penile pain are documented, and Bupa stated that no concerns about urinary retention were identified, and no other signs were reported by staff.

Response to concerns

37. Ms B raised concerns about Mr A's care directly to the community organisation, which resulted in the organisation's social worker arranging a meeting on 15 Month2 2020 at the care home between Ms B, the organisation's registered nurse, and Ms D to discuss concerns raised by Ms B regarding Mr A's admission and care, his transition to permanent resident status, and the end-of-life care pathway.

38. The progress notes include the following entry on 15 Month2 2020:

> '[The meeting] discussed the things that [Ms B] was unhappy about when [Mr A] came for admission. [Ms B] would like [Mr A] to stay permanently now. Reassurance given … asked her to see us if any concerns …'

39. Minutes of the meeting were not kept. Bupa stated that it would have expected the care home team to have clarified who was taking minutes and either followed up with the community organisation and requested a copy of the minutes or taken notes themselves. Because this was not done, it did not prompt the team to formalise the concerns within Bupa's electronic system (Riskman). Bupa told HDC that it has comprehensive work instructions to guide and support staff when receiving feedback or complaints, and Bupa expects receipt of any concern to be registered on Riskman, to allow appropriate review, intervention, and feedback to be completed. Bupa acknowledged that this was not completed and did not meet its organisational expectations regarding complaint management.

40. Bupa stated that its work instructions on complaints management reiterate the importance of feedback as an opportunity to strengthen and improve on relationships, the resident care journey, and whānau/resident communication. With hindsight, Bupa viewed this as a missed opportunity.

Room set-up and iced water

41. Ms B was concerned that the way Mr A's room was set up was not appropriate for his needs. She told HDC that at the meeting on 15 Month2 she raised her concern that Mr A's room was set up for a left-handed rather than a right-handed person, and she was told that the bed could not be moved as that is how palliative beds are set up.

42. The progress notes on 19 Month2 2020 record that Ms B was upset because when she arrived, she found the call bell under the bed and the overbed table near the window, and Mr A's mouth cares had not been done. Bupa stated that in response to Ms B's concerns, the staff received verbal reminders of care expectations, and a photo prompt was taken to visually remind staff of Mr A's preferences for his room set-up.

43. Ms B also stated that Mr A's water was often served without ice, despite his stated preference for iced water. Bupa responded that his preference for iced water was noted in the progress notes on 19 Month2 2020 and the corresponding clinical handover notes. However, due to the passage of time, Bupa was unable to confirm whether iced water was served on a regular basis.

Permanent resident

44. On 20 Month2 2020 Mr A was visited by a nurse from NASC. The notes from this visit include: '[S]acral pain. Please review for air mattress.' The notes from a visit by a different nurse the following day include:

> '[D]enied any sacral pain today, however I agree he would benefit from an air mattress if one available. [Mr A] is very frail now … Would recommend getting EOL [end-of-life] sub cutaneous medications charted at admission tomorrow in anticipation of decline …'

45. On 22 Month2 2020 Mr A received authorisation from the then District Health Board to become a permanent resident of the care home and receive palliative care. He was a permanent resident at the care home from 22 Month2 2020 until his death on 11 Month3 2020.

46. Bupa stated that once Mr A was a permanent resident it would have expected that the previous community interRAI assessment would have been requested, but it was unable to ascertain whether that occurred. Bupa said that following the transfer to a permanent resident placement, its expectation is that an interRAI is completed within 15 days, and Mr A's interRAI assessment was completed on 5 Month3 2020, which was within the expected timeframe for a permanent admission.

47. On 22 Month2 2020 the medical admission notes by Dr F include that Mr A was to receive palliative care, and that he was not managing his oral medication well and was drinking only water. The GP prescribed anticipatory subcutaneous medications.

48. The progress notes on 23 Month2 2020 include a weekly review and state: 'Skin is intact however redness (blanchable) noted at sacrum. Now on air mattress and positioning chart …'

49. There is no record of Mr A having a full nursing assessment at that time, or that personalised nursing care plans were developed to support his stay and end-of-life care.

Call bells

50. Bupa told HDC that it expects that all resident call bell activations are answered by staff as soon as possible. It acknowledged that from time to time, due to staff providing cares to other residents, there can be unexpected delays, or call-bell responses can sometimes appear longer as staff prioritise attending to the resident before deactivating the call bell. Bupa apologised for instances where that occurred.

51. The care home has an electronic call-bell system that allows monitoring and reporting to be completed retrospectively. Bupa stated that a review of the call-bell report for Mr A's room during the period of his stay has shown that there was a total of 174 individual call-bell activations. Of these, the minimum call-bell activation time was .01 seconds, and the maximum call-bell activation time was 28.58 minutes. On average, the call-bell activation time was 1.40 minutes.

52. Regarding Ms B's concern that there were instances of the call bell being pulled out of the wall or not being within Mr A's reach, Bupa stated that it is expected that after any care intervention the call bell is placed within safe and easy reach. Bupa apologised for times that this did not occur. It stated that if the call bell is pulled out from the wall, the call-bell system automatically alerts staff by activating the 'emergency bell', and from the call-bell report there are 10 instances where this may have occurred. To deactivate the emergency bell, staff are required to place the call bell back in the socket, and the longest time to do so was 1.15 minutes.

Eye drops

53. The GP electronic care notes on 29 Month2 2020 record that the GP had a discussion with Mr A and Ms B regarding his eye drops. Bupa told HDC that the GP then prescribed them on 1Chart, and the care home staff administered them as prescribed. The administration records show that Mr A occasionally refused administration of the eye drops, and they were discontinued by the GP on 9 Month3 2020.

Bed rails and fall

54. Ms B was concerned that Mr A was not provided with a bed with bed rails and said that this contributed to his fall on 6 Month3 2020. In response to the provisional opinion, Ms B said that Mr A was unable to move independently, and he and Ms B both requested bed rails for protection, not as a restraint.

55. Bupa told HDC that bed rails are devices that can be raised or lowered with sides that help prevent a resident falling from their bed, but they are not indicated to be used as a bed mobility aid. Bupa said that bed rails that are used as a mobility aid can increase the potential falls risk and pose a greater safety risk for residents.

56. Mr A was provided with a bed lever rather than a bed with bed rails. Bupa said that its staff are expected to assess each resident and determine the most appropriate equipment. Bupa told HDC that in order to use a bed lever appropriately, the resident must have the required upper body strength and control. The progress notes record that one staff member was able to assist Mr A to reposition and relieve pressure in bed or to turn over. It is noted on several occasions that Mr A was able to reposition himself with prompting.

57. Bupa told HDC that Mr A had an additional falls prevention aid in place in the form of a sensor mat at the bedside to alert staff to any attempts to move off the bed without seeking the support of staff.

58. Bupa said that the bed lever supplied to Mr A was the most appropriate equipment for him. However, care home staff consulted with Mr A on the possibility of using bed rails when this was suggested by the NASC nurse. The records on 27 Month2 2020 state that Mr A declined the use of bed rails.

59. The records state that on 6 Month3 2020 Mr A had an unwitnessed fall. However, in response to the provisional opinion, Ms B told HDC that she was told about Mr A's fall on 5 Month3 2020.

60. Ms B said that the fall occurred following the administration of oxygen and oral morphine. There is no mention in the progress notes or incident form of a sensor mat being in place at the time of the fall, and it appears that Mr A rolled out of bed. The incident report states that the 'maintenance man' found Mr A on the floor, and he was hoisted back to bed and had no injuries. However, Ms B stated that he had bruising to his head. The call-bell report shows an emergency activation of the bell at 7.38:59am, which suggests that no sensor mat was in place or connected at the time Mr A fell.

61. In response to the provisional opinion, Ms B asserted that the call bell was unplugged, meaning that the sensor mat was also not working, and she questioned why, if the emergency bell automatically triggers when a call bell is unplugged, Mr A was discovered by the maintenance man and not medical staff. However, there is no record that the call bell was unplugged at that time, and it appears likely that the call bell was activated when Mr A was discovered on the floor.

62. The fall was entered on Riskman on 6 Month3 2020. The care home nursing notes and external hospice nurse notes both refer to the fall from bed following a period of restlessness/agitation. PRN (as required) midazolam had been administered at 4.20am on 6 Month3 2020, and oxygen had been commenced at 2 litres via concentrator because of Mr A's low oxygen saturation and restlessness.

63. The electronic medication records indicate that morphine was not administered prior to the fall but it was administered after the fall for pain management, together with an additional dose of midazolam at 8.10am.

64. The nursing notes state that a bed with rails was provided following the fall, but this is not referred to in the Riskman investigation of corrective actions. Bupa stated that following Mr A's fall, no additional falls risk assessments were completed, but bed rails were placed as part of the falls risk prevention strategies.

Pressure risk and pressure injury

65. Bupa told HDC that it is expected that all residents admitted to a Bupa care home have their skin integrity and pressure risk calculated by a registered nurse as part of the admission process and then reviewed as clinically indicated as part of their ongoing care and reassessment processes.

66. The initial nursing assessment completed noted that Mr A had good skin condition but had a risk of deterioration with a healed previous sacral pressure injury. Bupa stated that although it is noted that an air mattress was required (as was used at home), at that stage there is no evidence that a formal pressure risk assessment or skin assessment was completed that would have indicated that an air mattress should be allocated to Mr A.

67. Bupa said that a positioning chart was initiated, and repositioning every two hours was required. However, the chart was not used routinely as Mr A often refused cares. Consequently, the staff used the progress notes to record the assistance provided.

68. Bupa stated that its expectation was that during provision of assistance for activities of daily living or pressure area cares, the staff would monitor and assess Mr A's skin integrity and report any changes or concerns to senior staff members. Care staff documentation in the progress notes on 18 Month2 2020 records redness on Mr A's sacral area. This was reported to the nurse, and a barrier cream was applied for protection. Bupa stated: 'We apologise that at this time a formal skin assessment was not completed, nor that in the following days no further formal follows up or interventions were adequately provided.'

69. After subsequent review by the registered nurse, a pressure-relieving mattress was provided on 21 Month2 2020, and a stage 2 pressure injury was identified on 24 Month2 2020. The care home staff logged this in Riskman, commenced additional wound-care assessments and plans, and initiated a short-term care plan (STCP).

70. A pressure injury on Mr A's toes was recorded on 28 Month2 2020 and entered into Riskman. Wound assessments and plans and an STCP were commenced. A bed cradle was provided on 28 Month2 2020 and Mr A's heels were elevated with a pillow.

71. Bupa stated:

> 'Bupa ensures that a range of equipment is available for use including bed extensions for taller residents and apologises if one would have been appropriate to be utilised for [Mr A] but was not.'

Fungal infection of fingernail

72. RN E stated that she had a discussion with Ms B and Dr F regarding Mr A having a nail fungal infection. Bupa said that the care home carries a limited amount of stock medications, and discussion with the GP noted that the topical ointment discussed would need to be dispensed from the pharmacy, which would take a couple of days. RN E said that as part of a clinician-to-clinician discussion about care options available for Mr A, she informed the GP that they had another type of antifungal cream in their imprest supply that they could begin to use immediately.

73. Bupa told HDC that all medications are required to be prescribed by the GP on 1Chart prior to administration by staff. The GP did not record a prescription for any topical anti-fungal cream and so care home staff could not start the application of the cream. Bupa stated: 'We apologise for any confusion created as a result of the professional discussion between the Bupa [staff], and that following this nothing was prescribed or administered.'

Wish to return home

74. Between 19 and 28 Month2 2020 Ms B raised several concerns regarding Mr A's care. On 28 Month2 it is documented in the progress notes that Ms B was considering removing Mr A from the care home and moving him to another facility.

75. On 4 Month3 2020 Ms B told the staff that she wanted to take Mr A home. Dr F attended on 4 Month3 and discussed the risks of taking him home.

76. Bupa told HDC that when Ms D heard that Ms B was thinking about removing Mr A, Ms D discussed with Ms B and Mr A that the usual termination timeframes require 21 days' notice, to ensure that they were aware of the process and that they understood that the care home would expect the service fees to be paid regardless of whether Mr A was in the facility.

77. Ms B complained that this conversation with Ms D was coercive. Bupa told HDC that Ms D apologised if the conversation was seen as coercive and stated that it was not meant to discourage Ms B from taking Mr A home for end-of-life care.

Deterioration

78. Bupa told HDC that Mr A's condition declined steadily after admission. Often he refused care and had a reduced intake of food and fluids. He was assessed by the GP and hospice at various times, and medications including analgesia and antiemetics were prescribed on 4 Month3 2020, and the community organisation's nurse recorded on 6 Month3 2020 that Mr A was 'entering his last days'.

79. Bupa said that subcutaneous medication was commenced via a syringe driver, and care continued to be provided to Mr A, including support for activities of daily living (washing,

changing clothes, assistance, and hygiene post elimination), moving and positioning in bed, and regular checks on his safety and comfort.

Staffing levels

80. Ms B stated that care home was short-staffed during the time Mr A was a resident.

81. Bupa responded that it had reviewed the staff rosters for this time period, and it confirmed that between 8 Month2 and 11 Month3 2020 staffing levels were affected by staff sickness.

82. Bupa stated that when faced with unexpected staff absence or shortages, it prioritises care accordingly, and the expectation for the care home at that time was that all steps available would be taken to ensure that the care and support required by residents was prioritised and provided on those days.

Further comment — Bupa

83. Bupa reiterated that the care home care team responded appropriately to concerns raised by Ms B regarding Mr A's room set-up, access to his call bell, and his preference for iced water. Bupa said that these were documented in the progress notes and clinical handover notes appropriately, ensuring that communication and changes to preferences were recorded and able to be implemented. Bupa suggested that feedback and response of this nature is commonplace within any healthcare environment.

84. Bupa stated that it wishes to acknowledge the stress and pain Ms B felt as Mr A entered the end stages of his life. Bupa acknowledged that this was a difficult time and expressed its sincerest condolences on Mr A's death.

Responses to provisional opinion

85. Bupa accepted the findings and recommendations in the provisional opinion.

86. Ms B was provided with the provisional opinion. Her comments have been incorporated into this report where appropriate. In addition, Ms B raised several concerns about HDC's process, all of which have been considered carefully.

87. Ms B said that the report repeatedly states that Mr A's EPOA had not been activated, implying that her role as his advocate was not relevant or valid. She stated:

- Mr A was non-verbal much of the time, hard of hearing, and entirely dependent on her to communicate his needs in his final weeks.
- Mr A pleaded with her to get him out of the care home due to the poor standard of care and neglect he endured, but his repeated pleas to leave were ignored by BUPA.

88. Ms B said that Mr A had a thick accent, which often made communication difficult for staff. As a result, she was frequently asked to clarify his needs, advocate for him, and ensure that his wishes were understood. She stated that the claim that Mr A directly refused bed rails fails to acknowledge this reality.

Opinion: Bupa Care Services Ltd — breach

Introduction

89. Mr A was admitted to the care home to receive hospital-level respite care from 8 Month2 2020 until 22 Month2 2020, following which he was a permanent resident at the care home from 22 Month2 2020 until his death on 11 Month3 2020.

90. I acknowledge that this was a difficult and upsetting time for Mr A's friend and support person, Ms B, and I offer her my condolences for her loss. I note Ms B's numerous concerns and disappointment with the care Mr A received in the last weeks of his life.

91. I consider that there were several departures from the expected standard of his care during Mr A's admission to care home, and that cumulatively these amount to a breach of the Code of Health and Disability Services Consumers' Rights (the Code).

Assessment and care planning

92. My in-house aged care advisor, RN Johnson-Bogaerts, advised that as there was no external clinical documentation, the assessment and care planning process would have been challenging for RN C, and the process was informed only by Mr A's presentation, responses from Mr A and Ms B, and RN C's nursing assessment skills.

93. RN Johnson-Bogaerts noted that RN C did not complete all assessments required for short-stay residents. Although some important items of care were documented, more in-depth assessments were not completed as follows:

- The mobility assessment part of the document noted that Mr A was dependent for his mobility and transfers, and that he would use a 'lazy boy/wheelchair, needs enabler'. It is not clear what is meant by the enabler and whether that referred to the bed lever he was provided with.
- The Falls Risk Assessment was only partly completed and concluded that Mr A was a low risk for falls despite his history of foot drop, vision impairment, low functional status, low appetite, and a recent history of anaemia, all of which are high risk factors for falls. Mr A also had a history of spinal stenosis and lower limb weakness.
- RN C completed a transfer plan to guide staff on how to support Mr A with transfers, but the plan does not provide an accurate picture for care staff on how to do this.
- The mobility part of the assessment notes that for mobility in bed, Mr A was a 'one person assist only'. The part relating to mobility walking aids/chairs, etc includes that he would use a frame for short distances, but it does not mention the use of a wheelchair and recliner chair, although the assessment document mentions these.
- The mobility plan does not include the use of a bed lever or whether Mr A was able to use it to mobilise or turn himself in bed. The positioning chart that was implemented is not mentioned in the mobility plan.
- The mobility plan was not updated when Mr A's needs for assistance changed over time.

- The falls risk assessment was not completed fully and, as a result, Mr A's falls risk may have been underestimated.
- The transfer plan was incomplete and too brief to guide and inform care across the shifts.
- Not all indicated assessments that were part of the admission documentation were completed, for example skin integrity and pain assessments.
- The baseline observations did not include documentation of Mr A's blood pressure.
- The skin assessment part of the document was not completed.
- The pain assessment part of the document included that Mr A had 'pain on his knees sometimes', but a full pain assessment was not completed.
- Mr A had an IPC in situ, but the care plan did not mention the type of catheter he had or the catheter care to be provided during his stay.

94. On 9 Month2 2020, the day following Mr A's admission, RN E returned to work and requested the care documentation from the referrer, the community organisation. This included a request for care requirements, the public hospital discharge summary, and the confirmation of respite care authority from NASC. It does not appear that the admission documentation and care plans were reviewed or revised on receipt of this new information, or that RN E reviewed RN C's documentation for completeness.

95. RN Johnson-Bogaerts concluded that the care and skill with which the initial assessments, the falls risk assessment, and the transfer plan were completed was lacking and was a mild to moderate deviation from accepted practice. I accept this advice.

Nursing assessment once a permanent resident

96. RN Johnson-Bogaerts stated that once Mr A became a permanent resident, it would have been expected that he would receive a full nursing assessment and have personalised nursing care plans developed to support his stay and end-of-life care. However, there are no additional nursing assessments and care planning besides the limited set completed at the time he was admitted for a short stay on 8 Month3 2020, despite his needs having changed as his condition deteriorated.

97. No comprehensive skin integrity assessment or pressure risk assessment was completed by the nurse at the time of admission or when his care needs changed. No care plan was in place to guide staff with interventions for prevention of pressure injuries. RN Johnson-Bogaerts noted that although there was an indication that this was required because of Mr A's difficulty with repositioning and the recommendations from the two visiting registered nurses regarding the need for additional pressure-relief interventions, including the provision of an air mattress, this was not actioned immediately, and an air mattress was provided only when a pressure injury began to develop three days later.

98. The Health and Disability Services Standards[2] required nursing care plans to be developed that were personalised, accurate, and kept up to date. The plans should describe the desired support and/or intervention to achieve the desired outcomes as identified by an on-going assessment process. The care plans were to be communicated to the health consumer/ family in an understandable way, and consent obtained. RN Johnson-Bogaerts stated that where the person is deteriorating and approaching the end of their life, good practice requires that a 'Last days of Life' care plan be developed, for activation at the time the dying process commences.

99. RN Johnson-Bogaerts advised that the absence of a formal skin assessment and delay in the use of an air mattress in the circumstances was a mild to moderate deviation from accepted practice. She considered that the overall lack of assessments and care planning was a moderate deviation from accepted practice. I agree with RN Johnson-Bogaerts' advice.

Complaints management

100. RN Johnson-Bogaerts advised that the care home Complaints Management Procedure was comprehensive and in line with good practice. However, the staff did not follow due process. Ms B's complaints were not registered on the care home's electronic management system, allowing for appropriate review, interventions, and feedback to be completed. Minutes were not taken of important meetings where concerns were addressed.

101. The Family Contact Record has no entries regarding the complaints and concerns raised by Ms B. The Progress Notes include the following entry on 15 Month2 2020 regarding the meeting held: '[R]e: discussed the things that [Ms B] was unhappy about when [Mr A] came for admission. [Ms B] would like [Mr A] to stay permanently now. Reassurance given … [T]o see us if any concern.' Although the issues raised appear to have been addressed at the time, the details were not documented and processed as required by Bupa's procedure.

102. RN Johnson-Bogaerts advised that the failure to follow Bupa's procedure was a mild to moderate deviation from accepted practice. I accept this advice.

Conclusion

103. During Mr A's admission to the care home there were several departures from accepted practice.

104. Mr A's admission on 8 Month2 2020 appears to have been affected by a breakdown in communication between Mr A, the referrer, and the care home. While I acknowledge the efforts of the registered nurse to complete the assessment and documentation in potentially difficult circumstances, I remain concerned that the actual standard of care delivered fell below expected standards in some respects (as discussed above). The care home had an obligation to provide Mr A with an appropriate standard of care, and it has not

[2] The Health and Disability Services (Core) Standards NZS 8134.1:2008 were replaced by Ngā Paerewa Health and Disability Services Standard on 28 February 2022: https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf (see Appendix B).

established that it took reasonable actions at the time of these events to ensure that it met that obligation.

105. Overall, I consider that there were several issues across Mr A's care, including his initial assessment; falls risk assessment; nursing assessments and plans; care home staff adherence to the complaints procedure; and pressure-injury care and monitoring. These failings involved multiple staff across the service, for which I consider Bupa was responsible. While I acknowledge that Mr A was becoming increasingly frail, the care home had a duty of care to provide an appropriate standard of care, and I do not consider that this standard was met. For the above reasons, I find that Bupa failed in its duty to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Involvement of EPOA — breach

106. Section 98(3) of the Protection of Personal Property and Rights Act 1988 provides that an attorney must not act in respect of a significant matter relating to the donor's personal care and welfare unless a relevant health practitioner has certified, or the court has determined, that the donor is mentally incapable. The EPOA must not act in respect of any other matter relating to the donor's personal care and welfare unless the attorney believes on reasonable grounds that the donor is mentally incapable.

107. By Ms B's account, Mr A had executed an EPOA for personal care and welfare, appointing her as his attorney. However, there is no evidence that the EPOA had been activated by medical certification, and there were no grounds to believe that Mr A was mentally incapable. Consequently, pursuant to Right 7 of the Code, services could be provided to Mr A only if he made informed choices and gave informed consent.

108. The care home had a responsibility to verify Mr A's legal status, and to be clear about the legal basis on which it was to provide services. Whilst that is important for all health and disability service providers, the fact that the care home regularly provides care to residents at the end of life means that it should have been particularly vigilant in respecting the rights of such residents. In my view, it was not acceptable for the care home to assume that Ms B had the right to make decisions on behalf of Mr A or that he did not have the capacity to make decisions for himself, and this shows a lack of respect for him and little awareness of the psychological impact that the loss of autonomy can have on vulnerable residents.

109. The care home should have sighted the EPOA documentation and considered whether Mr A had the capacity to make decisions on his own behalf. Given that there was no evidence that he was unable to make decisions for himself, the care home should not have arranged for Ms B to consent to his treatment or asked her to sign contractual documents. If it was thought that the EPOA had been activated prior to Mr A's admission, the care home should have asked to sight the certification required to activate the EPOA for personal care and welfare or otherwise ensured that it had been activated.

110. In response to the provisional opinion, Ms B said that Mr A had a thick accent, which often made communication difficult for staff. As a result, she was frequently asked to clarify his needs, advocate for him, and ensure that his wishes were understood. I acknowledge that

Ms B's role as Mr A's advocate was essential, and I commend her care for him at the end of his life.

111. I find it very concerning that the care home should clearly fail to be aware of the legal process in relation to consent for the care of residents such as Mr A. In my view, the care home failed to provide services to Mr A that complied with legal standards and, accordingly, breached Right 4(2) of the Code.

Admission process — adverse comment

112. Bupa told HDC that its pre-admission process includes receiving clinical information from external referrers relating to the care requirements of the consumer prior to admission. Based on the information gathered, suitability of admission of the prospective resident to the care home is determined, and if suitability is established, admission is agreed and planned. If agreed, the prospective resident and/or the next of kin receives a copy of the admission agreement, which is required to be signed before the commencement of care at the home.

113. However, Mr A's admission did not follow Bupa's usual pre-admission process. Mr A and Ms B arrived at the care home on 8 Month2 2020 without the care home having received a formal referral or clinical information, and without Bupa's pre-admission acceptance.

114. Despite RN E being unavailable because of illness, RN C did not contact Ms D to discuss Mr A's arrival and lack of documentation, or escalate the matter to any other senior staff member. RN C proceeded with the admission because the alternative was to send Mr A home or to a public hospital. Ms B was going away later that day, hence the need for respite care, so the nurse did not see these as appropriate options.

115. In my view, although RN C's actions were well intentioned, she should have sought support from a senior staff member, and I am critical that she did not do so.

Changes made

116. In Month3 2020 Bupa revised its work instruction that provides guidance on Supporting a Dying Resident and Their Whānau. This includes implementation of the principles and tools of Te Ara Whakapiri: Principles and guidance for the last days of life.

117. Bupa has strengthened its work instruction — Progress Reporting Work Instructions (Appendices 12 & 12a) to include:

> '[A]ll health care personnel who provide a resident with care, assessment, management and/or professional advice are responsible for documenting and dating this activity in the resident's Progress Notes …'

118. Bupa is transitioning all its care homes to VCare (an electronic document and care system), which allows greater transparency and prompts for resident care. Health professionals can either document straight into VCare, or team members can upload email/paper documents into VCare. The care home is now fully integrated into VCare.

119. Bupa requires all care team members to attend annual education on falls prevention and management, and annual competencies for manual handling. The team at the care home completed this in 2021 and 2022 and have attended other education sessions, where falls prevention and the guiding Bupa work instructions have been a focus. Bupa has continued to review and strengthen its guidance and review of resident falls, and its current work instruction includes stronger direction for post-fall review, which in turn promotes consideration of corrective actions for a resident.

120. Bupa teams have many opportunities to attend education and training regarding the complaints management processes, including annual complaints training, employee induction, national feedback and complaint sessions, and national clinical forums, and through national casebook learnings using anonymised examples of complaints and incidents to encourage critical thinking, reflection, and learnings. Specifically related to this complaint, the care home team attended a feedback session as a result of the review completed after receipt of this complaint in 2021, with an opportunity to reflect and learn from the issues raised.

121. The senior staff employed during the time of Mr A's admission are no longer working with Bupa.

122. Bupa stated that if an unplanned admission occurred in the future, the care home team would follow the Bupa admission process.

123. The care home team were supported by the Bupa Clinical Services Improvement team, as well as their regional Quality Partner, to work through this incident, encouraging reflection, critical thinking, and reference to the Bupa guidance, and an opportunity to strengthen their admission processes.

Recommendations

124. I recommend that Bupa provide an apology to Ms B and Mr A's family for the deficiencies in the care provided to Mr A, as outlined in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

125. I recommend that within six months of the date of this report, Bupa carry out the following actions:

a) In response to the provisional opinion, Bupa confirmed that its respite care checklists include a Braden Scale pressure injury assessment on admission, which is part of its new electronic record system, VCare. I recommend that Bupa provide HDC with documentation in support of this.

b) Undertake an audit of all residents at the care home who developed pressure injuries (any grade) over the previous six months and compare this to Braden Scale assessments to ascertain how well pressure injury risk is being identified and whether risk mitigation strategies are effective. At the same time, Bupa is to audit the documentation to ensure that pressure injuries have been restaged accurately, with treatment plans updated at each dressing change, and that appropriate reporting to the Ministry of Health and

Health New Zealand|Te Whatu Ora has occurred. The results of the audit are to be provided to HDC. If the audit does not show 100% compliance with the Braden Scale, please provide details of the further changes to be made to address this issue.

c) Undertake an audit of all residents at the care home admitted over a period of six months to ensure that all assessments and documentation have been completed. The results of the audit are to be provided to HDC. If the audit does not show 100% compliance, please provide details of the further changes to be made to address this issue.

Follow-up actions

126. A copy of this report with details identifying the parties removed, except the name of Bupa Care Services NZ Ltd and the advisor on this case, will be sent to HealthCert and Health NZ|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from RN Hilda Johnson-Bogaerts:

'CONSUMER: [Mr A]

PROVIDER: [The care home]

FILE NUMBER: C21HDC00015

DATE: 18 July 2021

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the care home]. 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. In particular I was asked to advise/comment on: whether reasonable care and skill was provided in the initial admission assessments, whether reasonable care and skill was provided in the falls risk assessment and transfer plan and whether there was an unnecessary delay in providing a bed with rails, whether the removal of [Mr A's] catheter was managed appropriately, the absence of a formal pressure risk assessment or skin assessment, and any issues of concern on the use of the air mattress, whether [Mr A's] fingernail fungal infection was managed appropriately, and whether the complaints process and communications with [Ms B] were adequate.

Documents reviewed

Provider's letter of response dated 18 February 2021

Admission medical summary form completed 22 [Month2] 2020

Clinical documentation including various monitoring charts, Medical Summary, Admission Assessment Booklet, 1Chart prescription chart, Whānau Contact Record

Progress notes (some copies were difficult to read due to colour of ink and due to some hard to read handwriting)

Complaints Management Procedure, Pressure Injury and Prevention Procedure, Restraint Minimisation and Safe Practice Procedure

Review of clinical records

[Mr A] became initially a short stay resident of [the care home] on 8 [Month2] 2020 to receive hospital level care for 14 days after he had been treated in hospital for delirium and sepsis. On 22 [Month2] 2020 he received authorisation from the DHB to become a permanent resident of the care home and to receive palliative care. His medical diagnosis included metastatic lung cancer with malignant pleural effusion managed with a drainage tube, atrial fibrillation, spinal stenosis with lower limb weakness, glaucoma, previous cerebral vascular accident. He needed support and assistance for all aspects of personal care, he needed full assistance with transferring and mobilising. He was well

supported by [Ms B] who visited regularly and was very involved with his care. [Mr A] subsequently died at the care home …

Clinical advice

Whether reasonable care and skill was provided in the initial admission assessments, whether reasonable care and skill was provided in the falls risk assessment and transfer plan and whether there was an unnecessary delay in providing a bed with rails

[Mr A] was initially admitted for a short stay of 14 days of hospital level care. As is the norm within the residential aged care sector, Bupa's pre-admission process includes receiving clinical information from external referrers relating to the care requirements of the consumer prior to admission. Based on this information suitability of admission of the prospective resident to the care home is determined, admission agreed and planned. If agreed, the prospective resident and/or next of kin receives a copy of the admission agreement which outlines all aspects of care and is to be signed before the commencement of the stay at the care home. The provider explained that this admission did not follow their usual pre admission process because [Mr A] and his next of kin presented at the care home on 8 [Month2] 2020 without the care home having received a formal referral from external assessors or clinical information, and without Bupa's pre-admission acceptance. The provider explained that the registered nurse on duty that day proceeded with the admission because the alternative was to send him back home or to hospital. Because [Mr A] initially came in for a short stay the admission process and documentation completed by the nursing staff on 8 [Month2] 2020 followed the process and documentation for short stays, which includes the completion of shortened assessments and care planning for immediate need, documented in Bupa's Admission Assessment Booklet. Reviewing the Admission Assessment Book I am concerned that the admitting nurse did not complete all assessments as indicated. While important items of care were documented, more in depth assessments were not completed. For example. The mobility part of the document was completed noting that [Mr A] was dependent with his mobility and transfers, it was noted that he would use a "lazy boy/wheelchair, needs enabler". It is not clear what is meant by the enabler and if this referred to the bed lever he was provided with. The Falls Risk Assessment was completed only partly and concluded he was at low risk of falling. I question this outcome as the documented foot drop, vision impairment, low functional status and low appetite (as per the assessment document) are automatic high risk factors for falls. A Transfer Plan was completed for the purpose of guiding staff on how to support [Mr A] with transfers. I am concerned that this plan does not give the full picture of assistance he needed to mobilise. For example for mobility in bed the nurse noted "1x assist" only. The part relating to Mobility walking aids/chairs etc. includes that he would use a crane (?frame) for short distances, and does not mention the use of or instructions for staff regarding the use of a wheelchair and lazyboy, while the assessment document mentioned these. The mobility plan does not include the bed lever or if [Mr A] was able to use this lever to mobilise/turn himself in bed. I would have expected that the document would refer to the positioning chart which was implemented. In addition, I am concerned that this Mobility Plan was not updated when his needs for assistance changed over time. Specifically relating to falls prevention I note the following. The

progress notes of 8 [Month2] 2020 include "enabler provided as per request". The provider response includes that this refers to a bed lever, a piece of equipment with a metal loop that extends up the side of the mattress to assist the person to move or change position. Such a tool is preferred over the full bedsides (sometimes also called cot sides) because the latter is seen as a restraint and discouraged as part of restraint minimisation goals as well as for safety reasons in aged care. Further regarding the initial assessment included in the Admission Assessment Book, I am also concerned that the skin assessment part of the document was not completed. The progress notes include that "Had broken skin on sacrum but already healed" and "positioning chart commenced to prevent skin breakdown". The Pain assessment part of the document included that he would experience pain "on his knees sometimes" however the full pain assessment form was not completed. In addition I am concerned that the admission notes do not include [Mr A's] blood pressure results as part of baseline vital signs taken. The next day [the senior staff] requested the care documentation from [the public hospital]. It does not appear that the admission documentation and care plans were reviewed/revised with this new information received.

In conclusion

Because there was no external clinical documentation the assessment and care planning process for the admitting registered nurse would have been challenging and informed by the person's presentation at the time and her nursing assessment skills only. Following Bupa's short stay admission process, the admitting nurse completed the Admission Assessment Book, wrote about the admission in the Progress Notes, developed some care planning, and commenced observation charts. I have found that the care and skill with which the initial assessment, the falls risk assessment and the transfer plan were completed to be lacking and to be a mild to moderate deviation from accepted practice. I have come to this conclusion because the documentation of findings was too brief to guide and inform care across the shifts. The falls risk assessment was not fully completed and as a result of this [Mr A's] falls risk may have been underestimated. The transfer plan was incomplete and too brief to guide and inform care across the shift. In addition I am critical that not all indicated assessments that were part of the admission documentation were completed (for example skin integrity and pain assessments) and the baseline vital signs did not include blood pressure. I note that the assessment mentions that he had a urinary catheter however there is no mention of the type of catheter care to be provided during his stay.

Whether there was an unnecessary delay in providing a bed with rails

It would appear that [Mr A] was provided with a bed lever rather than full bedrails in a timely way and on the day of his admission. This is in line with good practice and restraint minimisation goals. Over time when he deteriorated the visiting DHB RN recommended full bedrails so that he could use these to reposition himself in bed. However he was not provided with these at that time. The Whānau Contact Record of that time (27 [Month2] 2020) includes an entry of a conversation held between nurses and the next of kin and that it was concluded to wait "as [Mr A] is not in a great need". Unfortunately, on 6 [Month3] 2020 [Mr A] was found on the floor after he had rolled

out of bed. He was provided with full bed side rails immediately after this. In hindsight it would have been better if he would have been provided with full bedrails. Reviewing the documentation however I did not find in the notes of that time any indications (as for example restlessness) for the need to consider changing to full bed rails. Deviation from accepted practice — nil.

Whether the removal of [Mr A's] catheter was managed appropriately

[Mr A] had an indwelling urinary catheter in place at the time of his admission to the care home on 8 [Month2] 2020. On 9 [Month2] 2020 he complained of penile pain with a pain score of 10/10 and some blood in the upper tubing. It is not clear from the notes when the pain started. The nurses in first instance checked for symptoms of a urinary tract infection and pain relief was given, first paracetamol (12.45 hrs) and 10 minutes later morphine elixir as prescribed for pain. The clinical notes entered that afternoon include that the catheter was removed upon his request and after this was discussed with the [senior staff member]. This relieved his pain when checked at 14.30 hrs. The provider response includes that staff also had attempted to contact the GP to identify the clinical reason for the catheter and to provide guidance. The GP however did not respond. Staff then asked the [senior staff member] who approved for the catheter to be removed. In conclusion I consider the removal of the catheter to have been managed consistent with accepted practice. I have come to this conclusion because the nurses were appropriately prudent with the request to remove the catheter. In first instance they checked for a urinary tract infection which similarly can result in very high pain scores but would not be resolved by way of removal of the catheter. The nurses followed due process checking with GP and the senior [staff members], the issue was resolved within hours.

Advice on the absence of a formal pressure risk assessment or skin assessment and any issues of concern on the use of the air mattress

Bupa's response included that consistent with accepted practice it is expected that all residents admitted, are to have a skin integrity and pressure risk assessment to be completed by the RN as part of the admission process, and then reviewed as indicated as part of ongoing care and reassessment process. The initial nursing assessment at the time of the short term admission included that [Mr A] had a good skin condition but had the risk of deterioration with a previous sacral pressure injury. The pressure risk assessment within the bundle of the admission assessments was not completed. A repositioning chart was commenced on 18 [Month2] 2020 in response to noted redness and included the instruction for repositioning every 2 hours. This chart was not routinely used and the documentation includes that [Mr A] often refused to be repositioned. In the situation where repositioning is difficult an air mattress is indicated to relieve pressure and maintain skin integrity as much as possible. On 20 [Month2] 2020 [Mr A] was visited by a RN from [the DHB]. The notes from this visit include "sacral pain. Please review for air mattress." The notes from a different RN visit the next day includes, "… denied any sacral pain today, however I agree he would benefit from an air mattress if one available. [Mr A] is very frail now … Would recommend getting EOL [end-of-life] sub cutaneous medications charted at admission tomorrow in anticipation of decline …'

On 22 [Month2] 2020 [Mr A] received authorisation from the DHB to become a permanent resident of the care home and to receive palliative care. The medical admission notes on this day include that he is to receive palliative care, that he was not managing his oral medication well, drinking water only. The GP prescribed anticipatory subcutaneous medications. The progress notes of 23 [Month2] 2020 include a weekly review providing a very short overview "… Skin is intact however redness (blanchable) noted at sacrum. Now on air mattress and positioning chart …". I did not find evidence of any further comprehensive assessments or care planning as a result of this finding. Because [Mr A] had now become a permanent resident it would be expected that he would receive a full nursing assessment and have personalised nursing care plans developed to support his stay and end of life care. I did not find any additional nursing assessments and care planning besides the limited set completed at the time he was admitted for a short stay on 8 [Month3] 2020. I did not find evidence that these were updated when his care needs changed. The Health and Disability Services Standards require for nursing care plans to be developed that are personalised, accurate and kept up to date. They are to describe the desired support and/or intervention to achieve the desired outcomes as identified by an on-going assessment process. These care plans are to be communicated in an understandable way with the health consumer/family, and consent obtained. In the situation where the person is deteriorating and approaching the end of their life, good practice requires in addition for a "Last days of Life" care plan to be developed which is activated at the time the dying process commences. In conclusion: I consider the absence of a formal skin assessment and delay in the use of an air mattress in the circumstances to be a mild to moderate deviation from accepted practice. I have come to this conclusion because no comprehensive skin integrity assessment or pressure risk assessment was completed by the registered nurse at the time of admission and when care needs changed. This might have resulted in underestimation of the pressure injury risk. There was no care plan in place to guide staff with interventions for prevention for pressure injuries. While there was indication (difficulty with repositioning) and recommendations from the two visiting DHB RNs regarding the need for additional pressure relieving interventions including the provision of an air mattress, this was not actioned immediately and an air mattress was only provided when a pressure injury started to develop three days later. Further I would like to express my concern that I did not find evidence that the assessments and care planning were updated at the time [Mr A's] admission status changed from short term care to long term/end of life care and when over time his care needs changed. I understand from the provider's response that there were ongoing concerns regarding the signing of admission agreement. In such a situation the need for well documented and with the family agreed care plans is of even greater importance to ensure informed consent. In the circumstances this overall lack of assessments and care planning would be seen by my peers as a moderate deviation from accepted practice. I recommend that [the Bupa care home] implements the Ministry of Health's Last Days of Life care planning tools.

Whether [Mr A's] fingernail fungal infection was managed appropriately

The provider explained that a discussion took place between the nurses and the GP regarding a nail fungal infection and the need for the topical ointment to be prescribed

and dispensed from the pharmacy. Unfortunately following this no prescription was recorded by the GP and no application was commenced. This would be considered by my peers as an oversight.

Please comment on the complaints process and communications with [Ms B]

I reviewed Bupa's Complaints Management Procedure and found this to be comprehensive and in line with good practice. The provider acknowledges in the Letter of Response dated 18 February 2021 that in this instance staff had not followed due process. Receipt of complaints were not registered on its electronic management system allowing for appropriate review, interventions and feed-back to be completed. Minutes were not taken of important meetings where concerns were addressed. Reviewing the Family Contact Record I did not find any entries regarding the acknowledgement or content of complaint/concerns raised by family. The Progress Notes include an entry on 15 [Month2] 2020 that a meeting was held, "re: discussed the things that [Ms B] was unhappy about when [Mr A] came for admission. [Ms B] would like [Mr A] to stay permanently now. Reassurance given … to see us if any concern." It would appear that issues raised were addressed at the time however details were not documented and processed as required by Bupa's procedure. In conclusion it would appear that concerns and complaints were resolved by the nurses in an informal manner however due process as prescribed by the organisation's procedure was not followed. In the circumstances this would be seen by my peers as a mild to moderate deviation from accepted practice. This is because without following due process family may feel their complaints are not received with the importance intended and trust may be lost. In addition when complaints and their outcomes are not documented it is harder for these to lead to quality improvements. I recommend that continuing education be provided to the nursing staff regarding communication and complaints management to prevent a similar occurrence in the future.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor Health and Disability Commissioner'

Appendix B: Relevant standards

Health and Disability Services (Core) Standards NZS 8134.1:2008

'Standard 3.3 Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

3.3.2 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.

3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Standard 3.10 Consumers experience a planned and coordinated transition, exit, discharge or transfer from services.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.10.1 Service Providers facilitate a planned transition exit, discharge, or transfer in collaboration with the consumer whenever possible and this is documented, communicated and effectively implemented.

3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Standard 3.13 A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.

3.13.3 The personal food preferences of the consumer are met where appropriate.'

Nursing Council of New Zealand

The Nursing Council of New Zealand (NCNZ) publication Code of Conduct for Nurses (June 2012) states:

> '1.10 Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers.
>
> …
>
> 4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> 4.8 Keep clear and accurate records.
>
> …
>
> 4.10 Practi[s]e in accordance with professional standards relating to safety and quality health care.'