A Retirement Facility

Medical Officer in General Practice, Dr D

Care Manager, Ms E

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC00079)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Ms B	Complainant/Daughter of Mrs A
Dr C	Daughter of Mrs A
Dr D	Provider/Medical officer in general practice
Ms E	Provider/Care manager of Hospital, the Facility
Ms G	Director of Aged Care Services, the Facility
Ms H	General manager, the Facility
Ms I	Care manager of Dementia Unit, the Facility
Ms J	Registered nurse
Dr J	Rehabilitation services registrar, DHB 3
The Facility	Provider/Retirement Facility
The Hospital	Hospital within the Facility
Hospital 1	Large public hospital/DHB 1
Hospital 2	Regional public hospital/DHB 2
Hospital 3	Large public hospital/DHB 3
Hospital 4	Regional public hospital/DHB 4

Complaint

On 9 January 2006, the Commissioner received a complaint from Ms B about the services provided by a retirement facility to her mother, Mrs A. The following issues were identified for investigation:

- *The appropriateness and adequacy of the care provided by the retirement facility to Mrs A from 28 October to 9 December 2005*.
- *The appropriateness and adequacy of the care provided by registered nurse Ms E to Mrs A from 28 October to 9 December 2005 including the care of the sacral area, nutritional and dietary requirements and the administration of medication*.
- *The appropriateness and adequacy of the care and treatment provided by Dr D to Mrs A from 31 October 2005 to 24 November 2005.*

An investigation was commenced on 10 February 2006. The investigation has taken over a year to complete owing to the information gathering process and difficulties locating some parties.

Information reviewed

Information was obtained from:

- Ms B
- Dr C, Mrs A's daughter
- Dr D
- Ms F, Dr D's lawyer
- Ms E
- Ms G, Director of Aged Care Services, the retirement facility
- Ms H, General Manager, the retirement facility
- Ms I, Care Manager of Dementia Unit, the retirement facility
- Ministry of Health
- Nursing Council
- District Health Board 4
- District Health Board 2
- District Health Board 3

Independent expert advice was obtained from general practitioner Dr Ian St George and Jenny Baker, a nurse with extensive aged care nursing and management experience.

Overview

On 1 September 2005, Mrs A (aged 82) suffered a severe left sided cerebral vascular accident (CVA)[1] while on holiday in a large city. Mrs A was previously active and fit, but following her stroke she was left with little overall movement and limited control of her upper body following her stroke.

On 27 October 2005, following admissions to Hospitals 1 and 2, Mrs A was transferred to a retirement facility (the Facility) in another large city. Mrs A was a resident at the Facility for six weeks. During that time she experienced weight loss of approximately 10 kilograms, and developed a bed sore[2] that required surgical removal of the dead tissue, in an outpatient setting.

[1] Cerebral vascular accident: disruption in blood supply to the brain, commonly called a stroke.

[2] A bed sore or pressure ulcer/sore is also known as a decubitus ulcer. It can range from a very mild pink coloration of the skin, which disappears in a few hours after pressure is relieved on the area, to a very deep wound extending to and sometimes through internal organs and bone. A decubitus ulcer can develop in as little as eight hours in an immobile person.

Information gathered during investigation

Hospital 2

On 11 September 2005, Mrs A was transferred from Hospital 1 to Hospital 2 for further care and rehabilitation. She was assessed by Hospital 2 as requiring hospital level care. Mrs A had left-sided paralysis of her body, cognitive impairment and dysphagia.[3] She was unable to maintain an upright position on her own and could not move to relieve her pressure areas. She required assistance with all her physical care and dietary needs, and needed two nurses to transfer her. On 14 October Mrs A's weight was noted to have been 52.7kg during her Hospital 1 admission (Mrs A was not actually weighed on 14 October).

Due to a bed crisis at Hospital 2, Mrs A was discharged at 9.30pm on 27 October 2005 to the Facility. Her discharge letter noted:

> "[Mrs A] was admitted for rehab after having an intracerebral bleed. She has made only slow improvement. She is more alert than on admission, but still tires easily. She initially required subcut fluids, but can now manage with just oral intake with encouragement.
>
> …
>
> [Mrs A] is assessed as needing Hospital Level Continuing Care and a place was being arranged for her at a local facility. However, due to a bed crisis, management decided she should be discharged sooner so a bed was found in [another area]."

Mrs A's discharge medications were: simvastatin (a cholesterol-reducing agent), metoprolol (for hypertension/heart failure), Metamucil (to maintain regular bowel movement), Nilstat oral suspension (an anti-fungal medication for oral thrush) and paracetamol (1gm, as required).

The Retirement Facility

The retirement facility services include villas for independent living, a 30-bed dementia unit, and a 32-bed hospital wing. The hospital wing has 24-hour registered nurse cover.

Ms H was the general manager, and had overall responsibility for the operation of the facility. Care manager RN Ms E was responsible for the management of the hospital wing. She oversaw the daily care and requirements of the residents, supervised the nurses, and managed the care provided within the facility. Her job description stated that she was expected to ensure an "excellent quality of residential care" and promote the "optimum health of residents" by implementing and maintaining safe care practices and providing appropriate and safe care to residents. She was also responsible for ensuring that effective consultation occurred with general practitioners and other health professionals.

[3] Dysphagia: difficulty with swallowing.

The Facility's Director of Aged Care Services, Ms G, stated:

> "Prior to completing her full training, [Ms E] worked for many years as an enrolled nurse. She does not have a lot of management experience but regular meetings (3 times per week) were held between the two care managers and the general manager as part of mentoring her into that area of her practice."

In addition to Ms E, another registered nurse who undertook the daily nursing tasks was normally present during the day. The Registered Nurse job description provides responsibility for the co-ordination of nursing care and medical services for residents, in consultation with management. This includes the completion of admission details and the development of a "Short Term Care Plan" (within 24 hours of admission) and an individual "Lifestyle Plan" within three weeks of a resident's admission. The nurses were also required to ensure that appropriate reviews of residents' care occurred, and to facilitate access to other health care professionals as required. In addition, the nurses had responsibility to ensure all relevant documentation was completed and relevant information provided to the next shift.[4]

Admission to the Facility

Mrs A was admitted to the Facility's hospital wing shortly after midnight (at 0015) on 28 October. Mrs A's daughter, Ms B, was present.

The Hospital 2 discharge letter and medical records appear to have been sent at a later but unknown date. However, a referral form arrived with Mrs A. The form noted that her sacral area was reddened but intact, and recommended regular repositioning to limit further pressure on the reddened area. Mrs A had been on an air mattress while in Hospital 2. It was noted that she needed to be fed a soft diet while sitting up straight and that she was "slow to swallow". The referral stated:

> "[Mrs A] requires full assistance with all personal cares.
>
> Nutrition — is able at times with direction to feed herself, but we have found to maintain good nutrition and hydration feedings is necessary.
>
> …
>
> [Mrs A] is a delightful lady. Trying very hard to be co-operative, has periods of confusion of time and place.
>
> Skin integrity — sacral area red but intact regular positioning is necessary. While a patient with us she has been on an air mattress.

[4] The "Resident Care Planning and Monitoring Policy" required care staff to complete chronological progress notes detailing a full and factual contemporaneous explanation of what occurred.

…

> We do apologise for this very late transfer and very sorry it has been so rushed this is not our usual procedure and is beyond our control and due to a bed crisis here in [Hospital 2]."

The "resident assessment form" completed by RN Ms J on admission recorded that Mrs A had difficulties with mobility. Ms J noted the reddened sacral area and that "2hrly [hourly] turns" were required. Ms J partially completed the Waterlow score.[5] She gave Mrs A a total score of 13, but did not give a score for the appearance of her skin (which gives a score of 2 for "discoloured skin"), or a score for special risks (which gives a score of 4–6 for "motor/sensory problems").[6] Mrs A was noted to have moderate confusion with short-term memory loss, and to have oral thrush. She was also noted to be unable to feed herself.

The nutritional policy (dated 16 June 2005) states that residents should be weighed on admission, but Mrs A was not weighed. Ms B recalls being told by Ms E that weighing her mother was inadvisable as Mrs A was unable to stand safely on the weighing scales. Ms J noted that Mrs A's weight "used to be" 53kg. Ms E stated:

> "On admission, [Mrs A] was tired and frail as she arrived in the middle of the night. She had poor sitting balance at that time so we did not weigh her."

Ms G informed me that the Facility had scales that allowed the patient to stand or be seated. There were also weight forms which should have been completed to monitor the weights. However, she noted:

> "Staff were aware of [Mrs A's] frail state when she was admitted. Positioning her on the chair scales was not easy and initially it was felt that it was kinder not to subject [Mrs A] to this."

Later that day, Ms E performed an assessment, and completed a "short term care plan" (dated from 28 October to 11 November 2005) and a "resident lifestyle plan", detailing Mrs A's care requirements. Ms E noted that Mrs A would require full assistance with washing, dressing, mobilising, toileting and medications.

The Facility's "Resident Care Planning and Monitoring Policy" stated that a registered nurse or Care Manager would visit all new residents within 24 hours of their admission and develop a short-term care plan. The Care Manager would then complete a "Resident Assessment Form" (within six days of admission). The resident assessment form provides the basis for the long-term "Lifestyle Plan", which is developed by the registered nurse in consultation with the resident and his or her family.

[5] The Waterlow scale is a pressure sore risk assessment tool.

[6] A score of above 10 denotes a patient at risk of pressure area damage; a score above 15 denotes high risk; a score above 20, very high risk.

Pressure care management

The Facility's skin management policy highlights maintaining skin in the best possible condition through "diet, mobility, pressure area care, hygiene and the use of appropriate skin care products". The policy states that when necessary, a registered nurse will complete a "Pressure Area Risk Evaluation Form". If damage to the skin occurs, this means that it is to be treated under either the pressure area care policy or the wound care policy. If an ulcer has developed, staff are required to clean and dress it. A nurse must be asked to assess it and a wound chart begun. The wound policy states that a doctor should be called if the ulcer becomes infected. A swab must be taken and antibiotic treatment provided.

Ms E recorded that Mrs A's skin was "vulnerable". In the short-term care plan she noted "pressure sore on sacrum, two hourly turns" with the instructions "To monitor sore and report any changes". In the resident lifestyle plan Ms E also noted that "regular monitoring of pressure areas" was required and that Mrs A should be turned every four hours at night.[7] The pressure area risk was initially described as "possible".

Ms E described the sore as "superficial". She covered the sore area with a protective dressing. This action was not documented. Ms E said:

> "Any patients who were at risk of pressure sores were closely monitored by myself, and wound charts were reviewed and documented in the residents notes. I was always present, if possible, during the dressing's changes to assist the Registered Nurse and review any changes."

On the evening of 30/31 October, the progress notes record that Mrs A was turned every two hours overnight.

Nutrition management

The Facility's nutrition policy (dated 16 June 2005) states that the Facility will ensure that all residents will have their nutritional needs met in a way that is appropriate to their condition and level of dependence. Nutritional needs, likes and dislikes will be documented. Any special feeding requirements will be documented and adhered to by staff and any dietary supplements required will be administered accordingly.[8]

According to the Hospital 2 referral information, Mrs A could "eat at times with direction" but she required feeding (soft or stewed foods) to maintain good nutrition. Her daughter, Ms B, wanted her to be encouraged to feed herself. Mrs A's short-term care plan stated under dietary needs: "Encourage to feed herself and offer fluids". The lifestyle plan stated a

[7] This was amended to two hourly turns (at night) on 11 November because of the deterioration of the pressure sore.

[8] Additionally, the Pressure Area Care policy states: "Every effort will be made to ensure that the nutritional and hydration needs of residents are met." The Personal Cares Policy states: "Residents will be assisted with feeding and drinking if they are unable to manage these tasks for themselves."

"normal/soft" diet was required with dietary supplements.[9] It was also noted that Mrs A had impaired swallowing. The early morning progress notes[10] for 28 October documented "Puréed diet, needs feeding. Needs to be sat upright for all intake food and fluids." The evening progress notes documented: "Poor appetite (Puréed food served and tomato soup); Difficulty swallowing noted." A "resident special requirement form" (undated and unsigned) stated that Mrs A needed Ensure to help increase her body weight.

Ms E said that she asked that Mrs A be taken to the dining room at meal times so that her intake of food could be monitored, although this became more difficult when Ms B asked for her mother to be fed in her room. Ms E said that she regularly reviewed Mrs A's nutrition, and she ate well most days and had normal bowel and urine function.

Pain management

The resident assessment form noted "left side shoulder arm and leg" pain but it was not fully completed. The lifestyle plan notes "aching" pain in the shoulder, with the comment to monitor pain relief and review when necessary. The progress notes document that Mrs A received "10ml Panadol syrup, as we are still waiting for her medication".

On 31 October Mrs A was assessed by the Facility's physiotherapist who recorded that Mrs A was able to sit unsupported for two minutes, and should be transferred with a two-person "standing twist" and supported "at all times" with a pillow. Ms B was present during this assessment. It is documented that the physiotherapist advised Ms E that "a period of inpatient rehabilitation" should be considered.

Assessment by Dr D

Dr D, a medical officer in general practice (general practitioner), initially visited Mrs A on 31 October. Dr D was to be Mrs A's general practitioner while she was at the Facility. (Dr D worked at a nearby medical centre and explained that he had an "association" with the Facility.) He examined Mrs A in the sitting room in the presence of her daughter and a staff member. (Ms B recalled that the staff member was Ms E). Dr D recorded Mrs A's clinical observations, medical history, and allergies.

Dr D commented that Mrs A was stable and it was usual practice to visit these patients every three months. He expected any concerns regarding skin condition or nutrition to be monitored by the nursing staff. He noted "REVIEW [one week] approx" but explained that this referred to the possibility of re-assessment if Mrs A's condition improved, with the expectation that nursing staff would notify him if this occurred. Dr D's lawyer, Ms F, stated:

[9] An additional note on 14 November states: "nutritional supplements required".

[10] The documentation of Mrs A's care in the daily progress notes was undertaken mainly (at irregular intervals) by the registered nurses and physiotherapy staff. Caregiver staff also completed a Daily Resident Review Form, which is a template with ticks or a code to be entered against activities of daily living (ADLs), with no space for written comment (an A4 page of the template captures two weeks of care).

> "[Dr D] was not aware that [Mrs A] had a sacral pressure area at this visit, and he had no notes from [Hospital 2] alerting him to any potential problem, so he did not examine this area at this visit."

Ms B noted that sacral redness was mentioned on both the nursing referral form and the resident assessment form.

Ms G commented that there "may have been a delay" in receiving Mrs A's complete clinical record from Hospital 2, because her transfer was carried out "in such a rush".

Care and treatment following initial reviews

On 2 November, the progress notes document that Mrs A was turned two hourly overnight. On 3 November, the resident report form[11] records that the sacral area was not improving, and requested two hourly turns. It was also noted that Mrs A weighed 45kg (this note appears out of sequence and on the back (blank) page of another resident report form).

On 4 November the evening progress notes documented "[Mrs A] ate her tea not much she didn't drink much" and, later in the night, "Push fluid as she is very dry."

There were no entries in the daily progress notes by nursing or care staff from 5 November until 12 November. However, there were entries in the daily progress notes by the Facility's physiotherapist on 7 and 12 November.

On 7 November, Ms E commenced a "wound chart" and recorded that the sacral sore was 2cm in size, and "superficial". She treated it using Opsite gel,[12] and requested that the sore be reviewed again on 9 November. Ms E next reviewed the wound chart on 10 November (rather than 9 November, as planned). She recorded the same description as 7 November. The next review date she requested was 14 November — but the chart was not updated until 22 November.

Ms E informed me:

> "[T]his did not get done. Normally this would have been the responsibility of the morning registered nurse."

A second wound chart was also commenced on 7 November (by another registered nurse). It recorded that the wound was "small" with a "broken area and a bit sloughy". No review request date was entered. The next review on this chart occurred on 24 November.

[11] Ms G explained that changes in a resident's condition or new information were recorded in the resident report form, to facilitate exchange of information between shifts — to supplement the daily progress notes and verbal handover.

[12] Opsite Gel: A clear water-based gel that provides a buffer to protect the wound from infection and promote healing.

Ms G commented:

> "Two Wound Care Charts were commenced, one by [Ms E]. She documented that the pressure area was small and superficial. Following her going on leave, two of our registered nurses, whose practice we have concerns with, have made subsequent entries. The form has not been used correctly or filled in adequately over that time."

On 8 November the DHB 3 rehabilitation team received a referral from Ms E requesting input into Mrs A's rehabilitation.[13]

On 10 November the Daily Resident Review[14] form records that Mrs A was turned two hourly at night.

Family meeting

On 14 November Ms B and Dr C met with Ms E to discuss concerns about Mrs A's weight and pressure areas. Ms B stated:

> "First, we had concerns about her weight, which in less than three weeks had been visibly dropping. We asked had she been weighed since being at '[the Facility]'. She had not. [Ms E] maintained she was eating well, and that there was no cause for concern. We disagreed — based on what we could see and asked that she be given the dietary supplements as she had received in [Hospital 2]. [Ms E] did not believe that she needed them. We asked that she be weighed weekly henceforth. This weighing only happened after the family insisted and watched it happen … Her first weight was confirmed at 5kg less than when in [Hospital 2]. It continued to drop another 3kg during the ensuring weeks.
>
> Secondly, we asked about the pressure areas. [Ms E] said these were being dressed and covered with Opsite. I asked if the GP could (or should) see them and she said the GPs do not usually concern themselves with such nursing matters and if nursing staff had any concerns they talked to a dressing company."

Ms B requested that her mother's mattress be replaced because the physiotherapist told her that the mattress was not suitable for a person with pressure sores, as it was made of foam. However, Ms E said that she was unable to purchase any new mattresses without management approval, and told Ms B that the family would need to purchase any other pressure-relieving equipment and mattress.

Ms E stated that a detailed plan for the care of Mrs A was formulated at this meeting, and the sacral area was identified as "vulnerable". She commented that doctors do not routinely

[13] Mrs A was subsequently assessed on 21 November.

[14] The Daily Resident Review form documents that Mrs A was turned two hourly in the evening on 14, 16 and 17 November. Otherwise, the form code is "AR", denoting that Mrs A required assistance with mobility.

examine pressure sores in the early stages, and there was no documentation to show any deterioration at this stage. Ms E stated that the need for dietary supplements was also discussed, and she noted on Mrs A's lifestyle plan that dietary supplements were required. However, Ms E stated that she "forgot" to ensure that Mrs A was given dietary supplements before going on leave (on 17 November). Her notes of the family meeting record:

> "Staff Assignment
>
> [Ms E]: I did explain if it was possible I would try and allocate the same staff member to see to [Mrs A's] needs.
>
> Feeding/Weighs Weekly
>
> [Ms E]: I did say as [Mrs A] has no sitting balance this would be hard to get an accurate reading. [The] (physio) would be working on this.
>
> Pressure Areas
>
> [Mrs A] came in with a superficial sore on sacrum. This only required a protective dressing. Ideally if possible [Mrs A] needs to be kept off her sacrum at all times. She was very reluctant to do this and despite pillows, still managed to go back. There were discussions about hiring a roho mattress,[15] but this was only ideas, nothing had been definitely decided. I explained to the family that all our mattresses are pressure-relieving.
>
> Feeding
>
> To encourage [Mrs A] to feed herself a lipped plate would be used."

Ms E added that the physiotherapist was mistaken in believing the mattress to be foam. Ms G confirmed that all mattresses at the Facility were pressure-relieving "Apollo" mattresses, designed for a lighter body weight. The "Apollo" mattress was supplied by Invacare. According to the Invacare website,[16] the Apollo mattress is a basic pressure-relieving mattress. It is made of "solid latex foam" and is recommended for those individuals "with a medium risk of developing pressure sores". The Invacare catalogue states:

> "Apollo foam is sensitive to temperature and therefore reacts to the heat of the body and moulds to the exact contours, promoting optimum pressure relief, support and comfort. Use Apollo as standard mattress in hospital and homecare beds, or as your preferred aid in prevention of pressure sores.

[15] Ro-Ho mattress and cushion: Ergonomically designed air-filled equipment designed for minimum skin tension on contact.

[16] http://www.invacare.com

> Features: Patients having pressure sores classified as stage 1 or 2 sores. Individual assessed to be at medium risk of developing pressure sores."

Ms E acknowledges that the Facility should have provided any additional pressure-relieving equipment, as required. Ms E informed me that she was not fully aware of the Facility's responsibilities in this regard. The Facility's "Pressure Area Care" policy (dated 9 April 2005) states that on admission, all residents will have a pressure area assessment completed by the Care Manager or RN. The Facility will provide "all necessary cares" and specialised equipment (such as mattresses) to reduce the risk of pressure areas developing when an increased risk has been identified. However, Ms E commented that she "was not allowed" to purchase any equipment or dressings as they were "too costly". She stated:

> "As previously explained the mattress provided, was felt, by the management to be adequate for all pressure area needs."

No specific reference about the pressure area is made in the daily progress notes until 15 November, when it was noted: "Dressing required before personal cares, appeared in pain [left] side when touched to move." The wound chart was not updated.

Responsibility for Mrs A's care

Ms E was on leave from 17 November to 6 December. In her absence, Ms H and Ms I (Care Manager of the Dementia Unit) took responsibility for Ms E's duties. Ms E said that Mrs A's care was handed over to Ms H and Ms I during meetings about the residents. Ms E said that "no pressure sore had developed" prior to her going on leave" and there was no need for a medical review but she "emphasised Mrs A's sacral sore needed to be closely monitored". She stated:

> "Prior to my going on leave I left clear instructions with Care Manager from the Dementia Unit, [Ms I] who, with the General Manager [Ms H], were left in charge of my residents."

Ms H recalled that, prior to going on leave, Ms E informed her that Ms B had been concerned about various aspects of her mother's care, and highlighted that she should be aware of this. She recalled that Ms I was present during discussions. Ms H said she was aware that Mrs A had a pressure area but at that stage there was no pressure sore, and she was not alerted to any particular concerns. Ms H explained that the registered nurses were expected to monitor and assess Mrs A as required. She visited the hospital wing on occasion and was normally told "everything was fine". However, problems occurred because registered nursing staff did not monitor the pressure area. Ms H commented that she did have some awareness about concerns around the performance of several of the registered nursing staff at the time, but was not aware of significant concerns.

Ms I did not recall being present at any formal meetings to hand over care of the hospital wing, although she believes there were meetings between Ms H and Ms E. She stated that

Ms H had overall responsibility for the Facility's Hospital in Ms E's absence. Ms I commented that Ms E asked her informally to "keep an eye" on the hospital wing. She does not recall any specific instruction about a pressure area. However, Ms I was generally aware that Mrs A had a pressure area, and knew that her family was dissatisfied with the level of care she was receiving. Ms I recalled asking the registered nursing staff about the pressure area, and being advised that it was not deteriorating.

Ms G explained that, in Ms E's absence, the registered nursing staff were responsible for the "ongoing care and supervision of residents". She stated:

> "Whilst [Ms E] was on leave … [Ms H] took over the management aspects of her role and the registered nurses were expected to take responsibility for the resident cares and the general day-to-day issues in the hospital wing.
>
> [Mrs A's] pressure area was adequately assessed in the initial stages. It was only following [Ms E] … going on leave that the ongoing monitoring and assessment was inadequate. This was when the area broke down and became a major wound.
>
> …
>
> Whilst the Care Manager was on leave, none of the registered nurses took any responsibility for monitoring and reporting on the state of the pressure area. This involved five nurses … It was not until the pressure area was at quite an advanced state that the resident's GP was notified."

Ongoing care

On 18 November, another physiotherapist[17] assessed Mrs A and requested that she be encouraged to mobilise with regular changes of position to assist with pressure relief. She noted:

> "Pressure relief to assist with current coccygeal/sacral pressure sore — ? Spenco."

On 19 November it is documented that Ms B requested that her mother feed herself. The physiotherapist noted "still [pain] as yesterday".[18] One gram of paracetamol was charted for Mrs A, as required.

On 19 November, the resident report form states:

> "[Mrs A] her daughter wants to feed by herself. Wants her to practice that. Daughter wants to have pain relief [please] fax the letter which is on the fax machine to [Dr D] to have the prescription for pain relief."

[17] This physiotherapist was employed by Mrs A's family to provide regular physiotherapy from this date.

[18] There are no further entries by the physiotherapist in the progress notes after 19 November.

The facsimile to Dr D stated:

> "[Mrs A] is always in pain (according to her daughter). She wants her mum to be prescribed with a pain relief medication. From [Hospital 2] medical record she was charted paracetamol 1gm PRN. The daughter wants it changed to liquid."

On 20 November, the resident report form notes "[Mrs A] PM meds not given discarded".

On 21 November, Mrs A was assessed by a DHB 3 physiotherapist and occupational therapist. It was decided that further discussion with the multidisciplinary team was needed before formulating a rehabilitation plan. The occupational therapist advised Ms B to liaise with the Facility as soon as possible to obtain "high" pressure-relieving equipment to prevent deterioration of the pressure area. The progress notes record that Mrs A weighed 45kg. The evening progress notes for 21 November state:

> "[V]isited by daughter [Ms B] in the late afternoon. [Ms B] concern re [Mrs A's] pain relief, if she could have pain relief regularly instead of PRN as [Ms B] is unable to tell if she is in pain or not."

Pressure sore care

On 22 November the registered nurse recorded, "Decubitus ulcer on sacral area. Dressed and ulcer healing cream applied." The wound management chart instituted by Ms E was updated on 22 November and states "ulcer repair Mebo gel". The resident report form requested two hourly turning, with sleeping on her side. The morning progress notes also document:

> "Visited by daughter … Requesting too that [Dr D] should see [Mrs A] for some dietary supplement, and some changes in her panadol (from tablet to capsule form). Faxed to [Dr D] this am."

The facsimile to Dr D stated:

> "[T]he daughter is requesting another change! She wants the panadol in capsule form. Or any pain relief for that matter."

The medication administration chart shows that Mrs A was given paracetamol on two occasions on 22 November.

On 23 November, the RN on duty documented in the progress notes:

> "Broken skin around sacral area, developed into an ulcer. Two hourly turns to patient to prevent further ulceration. Pain on movement. Panadol not tolerated well. Poor appetite this duty."

On 23 November, the multi-disciplinary rehabilitation team at DHB 3 met to discuss Mrs A. It was decided that inpatient rehabilitation was not indicated at that stage. However, further assessment was planned, with rehabilitation services registrar Dr J to undertake a joint assessment on 30 November.

The resident report form notes a left ulcer on the sacral area. Regular doses of paracetamol 500mg were charted for Mrs A. Multivitamins were also prescribed by Dr D.

Ms B stated that she telephoned Dr D and raised concern about her mother's sacral sore and weight loss. She expressed concern that the nurses were not taking care of her mother appropriately and that regular pain relief was not being given. Dr D agreed to meet with her and review her mother on 24 November.

Review by Dr D
Ms B recalled that Dr D examined her mother on 24 November, but did not look at the sacral area. Dr D told her that the nurses were responsible for the treatment of sacral sores, and they would inform him if they were concerned. Ms B said that Dr D explained to her that it could not be established whether her mother was losing or gaining weight as her weight had not been taken on admission and "any weight taken now would be academic". Ms B said that she was "stunned by this logic" and told Dr D that she could "plainly see her mother had lost weight".

Dr D recalls the visit differently. In a letter dated 26 June 2006, he stated:

> "My notes record my attendance on 24 November 2005 and that I discussed with [Ms B] nutritional issues, the sacral area and the following up of the pressure mattress. I also noted the need for monitoring of the sacral ulcer. I did explain to [Ms B] that good nursing practice was required to deal with pressure areas rather than medication/specific medical interventions. I certainly did not decline to examine [Mrs A]."

Dr D recorded:

> "Visit — Discussion with [Mrs A's] daughter
> — nutrition
> — pressure area — sacrum
> — physio
> — due for Rehab r/v [review] next week
> — joint pain
> O/E [on examination] knees/ankles — no significant swelling/redness Mild deformity → prob [probably] OK
> For regular paracetamol 1g QDS [four times a day]
> ? for ensure regularly / needs regular weekly weigh
> To monitor sacral ulcer
> Waiting for mattress

Rx [prescription] vitamins
? for zinc tablets
R/V 1/52 [review in one week]"

Dr D's lawyer, Ms F, subsequently informed me (on 30 August 2006):

> "As a result of a telephoned request by [Ms B], [Dr D] arranged to see [Mrs A] on 24 November at a set time. He [Dr D] instructs me that he expected [Ms B] to be present but she was not. [Dr D] recorded the issues of concern in the notes (as per the telephone conversation) and examined [Mrs A]. This examination included an examination of her sacral area and instructions to the nursing staff as per his notes."

Dr D advised that the annotation "discussion with [Ms B]" refers to his discussion with Ms B prior to his review of her mother on 24 November, and not during the review itself. He advised that he spoke to Ms I during his visit and discussed with her the fact that Ms B did not attend the arranged meeting, and that he also discussed with her Mrs A's ongoing management. Ms I does not recall the conversation.

Dr D further noted that he did examine Mrs A's sacral region on 24 November, and noted the pressure area. He explained that the reference to Mrs A's pressure area in the notes was brief because, at that time, it was a minor pressure area/early ulcer and "the condition was such that a detailed description was not warranted". He advised me that it sufficed to describe the area in the notes as "pressure area — sacrum". Although he did consider specialist intervention, he decided that the state of Mrs A's sacral skin did not warrant specialist intervention at that time and nursing care was sufficient. In making this decision, he was cognisant that Mrs A was due to be reviewed by a representative of the hospital, and thus considered that there was little to be gained from sending a referral to a specialist at that time.

Dr D recalled that he discussed the possibility of referral for specialist care with Mrs A's daughter, Dr C, and that she agreed with him. Dr C recalls speaking with Dr D about her mother's management at some stage, most particularly regarding his recommendations as to other places she could be transferred to. Dr C could not recall when the conversation occurred, and although there may have been some general discussion about the sacral sore, she does not recall any discussion about specialist intervention.

Ms B stated that she did attend the 24 November appointment as arranged, and she drew attention to the note by Dr D of their discussion. She recalled missing a later consultation with Dr D on 1 December, due to a misunderstanding about when Dr D was coming to see her mother. Ms B stated:

> "[The medical records for 24/11/05] clearly note I raised my concern about the sacral area at the start of the meeting. Certainly [Dr D] did not *decline* any

> examination, but nor should a patient have to expressly *request* an examination, for it to be appropriate for a doctor to investigate."

As recorded above, Dr D prescribed zinc supplements. The family were also advised to purchase a dietary supplement until further supplements could be prescribed by the registrar from the DHB 3 Rehabilitation team. Dr D commented that he was aware that Mrs A had a pre-arranged appointment for assessment by the hospital doctor on or around 1 December. He explained that Mrs A had deteriorated, and stated:

> "I considered that the Rehabilitation Registrar at his scheduled appointment would expedite hospital attention for the patient which he subsequently did. If he had not taken this action, I certainly would have."

Ongoing care of Mrs A

Later on 24 November, Ms I met with Mrs A and her daughter. (Ms I commented that Ms H instructed her to "sort out" Ms B's concerns.) A summary of this meeting was retrospectively recorded in the progress notes on 25 November by Ms I. She noted that the meeting was "to discuss concerns around pressure areas, nutritional needs, and the need for some kind of pressure-relieving device". It was agreed to obtain Complan from the Facility kitchen, and to review the pressure sore dressing and equipment. An additional note indicates that Complan was not available. Ms B commented that Ms I was of the view that two- to four-hourly repositioning was sufficient.

Ms G commented:

> "Once her [Mrs A's] weight loss was known to be of concern and, on the GPs instruction, weekly weighs were commenced. There are specific forms that this should have been recorded on but these were not used."

There are no further entries in the daily progress notes after Ms I's note of 25 November until 1 December.

On 25 November, a "Care Goal" chart was completed for Mrs A, stating that her weight was to be monitored weekly "each Monday" and that a referral was to be made for nutritional supplement. A decision on a pressure relief mattress was to be made by 30 November.

On 25 November, the Facility sent a fax to Dr D to arrange for Arginaid and Fortisip (dietary supplements) to be prescribed for Mrs A, on Ms B's request.

The following day, Dr D faxed a letter to the Facility asking for the drug chart so he could prescribe the medication requested. He also reminded staff:

> "Fortisip (like ensure) has to be applied for by a specialist. I believe [Mrs A] is due to be assessed by the rehab registrar soon. The issue of ensure/fortisip could be discussed

at this time. In the meantime I have suggested using some Complan (discussed with [Ms I] last week)."

On 26 November, the dressing of the sore is described on the wound chart, but there is no description of the condition.

On 28 November, the wound chart instigated by Ms E describes the sore as an "ulcer" with a "smell", which required cleaning and redressing. Nilstat oral suspension (for oral thrush) was charted for Mrs A by Dr D.

Review by Dr J

On 30 November 2006, Dr J, registrar for rehabilitation services at District Health Board 3, examined Mrs A to complete the assessment of her suitability for stroke rehabilitation. He was concerned that the pressure area sore had become necrotic and infected. He asked for an urgent outpatient appointment at the DHB 4 plastic surgery clinic. Dr J also advised the Facility to provide Mrs A with a Ro-Ho mattress and cushion,[19] as previously suggested by the physiotherapist. Dr J also referred Mrs A to a dietician and a physiotherapist specialist in rehabilitation.

Further review by Dr D

Dr D visited Mrs A on 1 December. He noted that her weight was 41.5kg and that she still needed nutritional supplements. The progress notes record "Doctor voiced concerns regarding weight loss and has requested that [Mrs A] receive complan regularly". Dr D advised continuing with nutritional supplements. There is no comment recorded about Mrs A's sacral sore. The dressing of the sore is described on the wound chart, but there is no description of the condition of the sore. It appears that an Elite pressure mattress and seat cushion were installed for Mrs A on 1 December.

The evening progress notes record that Mrs A was given Ensure and that she received "strict" two hourly turns, with repositioning during the day. The morning progress notes on 2 December document two hourly turns "with pain on turning".

Surgery for pressure sore

On 2 December, Mrs A attended Hospital 4 outpatient department to be assessed by the plastic surgery department. On initial examination, the surgeon described a 4cm area of necrotic tissue, 2cm deep, on Mrs A's sacral area. The wound was debrided and dressed. The surgeon recommended daily changes of the dressing, and instructed that Mrs A was not to lie on her left side and was to spend limited time on her right side. The surgeon further recommended some sitting at a 90 degree angle and turning every two hours.

[19] Ro-Ho mattress and cushion: Ergonomically designed air-filled equipment designed for minimum skin tension on contact.

Further care at the Facility

Ms B expressed concern that two hourly turns were not completed, particularly at night. She commented:

> "Despite [the instructions from the Plastics Clinic] family members arrived more than once to find her lying on her back on the affected area. We then realised that some caregivers had not understood instructions about the recommendations — had they even been conveyed."

The evening progress notes for 2 December document "strict 2 hourly turns were maintained turns chart completed". Ms G commented that staff she spoke to were "adamant" Mrs A was not left on her back, but Mrs A moved herself onto her back. In contrast, Ms B disputed this. Ms B stated:

> "She [Mrs A] has not ever managed this. Then, as now, she cannot initiate, nor complete any movement from side to back. Once positioned off her sacrum, she stays that way."

Ms G acknowledged that, on occasion, staff may not have returned Mrs A to her bed after lunch each day. She stated:

> "I believe that during the night it is important to allow residents the opportunity to have some uninterrupted sleep, hence we try to leave residents on four hourly turns. This is particularly so if we have additional pressure-relieving mattresses in place."

From 3 to 8 December, Mrs A's wound was dressed daily and recorded in the progress notes. The wound care chart was not completed. There are also a number of references to two hourly turns, and the resident report form documents that two hourly turns were maintained.

On 4 December Ms B was upset to discover that Dr D's prescription for multivitamins (to assist with healing) had not been actioned by the Facility. A facsimile from the Facility to a pharmacy states:

> "I'm faxing you [Mrs A's] drug chart. She doesn't have multivitamins in her drug folder … Could you please have the multivitamins ASAP."

The resident report form states:

> "[Mrs A] fax drug chart to pharmacy. Make sure she get[s] the multivitamin and the caplet paracetamol. Could sit up on a chair as long as the sacrum is not on support back with pillows."

Ms B was also concerned that her mother may not have been receiving Ensure as it was not charted. These matters were discussed with the registered nurse. From this date there are

regular references to Ensure and feeding in the progress notes. The application for Ensure was made on 6 December.

On 7 December, Mrs A was seen by Dr D. He recorded her weight as 44.3kg, and reviewed her pressure sore as "mild erythema, mildly offensive smell".

Later that day, a family meeting was held to discuss Ms B's concerns about her mother's care. It was noted that there had been "some shortfalls" while Ms E was away with "no prevention of pressure sores due to lack of care". The evening progress notes confirm two hourly turns and state "all meals to be taken in dining room under supervision and food chart commenced".

Transfer to a private medical hospital

On 9 December, due to Mrs A's family's concern about her care and well-being, she was transferred to a private medical hospital. Ms B stated:

> "In six weeks [Mrs A's] condition worsened, she lost 15–20% of her body weight, and a small superficial pressure area developed into a serious necrotic ulcer.
>
> We believe 'the Facility' lacks the robust systems and management practices — particularly record keeping, overall staff and patient supervision, and communication between staff on different shifts, to adequately care for high needs patients like my mother, despite being contracted to provide services at this level.
>
> …
>
> When the care manager, [Ms E] went on holiday for three weeks from 17 November to 6 December, adequate cover for her duties was not provided. We were told the [Ms H] would be in charge of the hospital but it appeared that the day to day running of the facility was left to the duty RN. There was no one acting as manager in a 'hands on' capacity until [Ms I], the Manager from the attached Dementia unit, became involved to sort out problems that had developed in [Ms E's] absence. We should note that the problems we had were developing before [Ms E] went away."

Response by the Facility

Ms G undertook a full review of the Hospital complex. She identified a lack of management systems and supervision within the Hospital, together with concerns about the competency of several of the registered nursing staff.

Ms G acknowledged that the Facility and staff did not provide care of an appropriate standard to Mrs A and she apologised to Ms B. Ms G explained that, in her opinion, a number of the nurses employed at the Facility were not working to the required standard. Ms G stated:

> "Our key concerns were poor communications (with families in particular), poor supervision of staff (especially her registered nurses), a lack of systems and procedures within the unit and poor documentation.
>
> …
>
> In her [Ms E's] absence the registered nurses were expected to be responsible for the ongoing care and supervision of the residents. This is when the short falls really became apparent. Checks were not carried out as they should have been, communication was poor and documentation was very limited.
>
> …
>
> I had become aware that the documentation provided by our pharmacist was not adequate, in that the administration forms which staff sign when giving out documentation did not record any details of what the medications were. This resulted in us having no way of knowing, from these forms, when new medications were commenced. This has since been rectified, following meetings with the pharmacy."

In a letter to Ms B dated 17 February 2006, Ms G stated:

> "I will be working with the registered staff to provide training and support to ensure they are fully aware of documentation requirements and staff supervision expectations. I will be monitoring the hospital residents on a regular basis as well, to ensure their appearance and cares are completed to my satisfaction.
>
> All our facilities have the necessary policies and procedures in place and we readily supply up to date, quality equipment and provisions. There has never been an issue around this although I do believe the processes around this may not have been adequately explained to [Ms E], hence there has been some misinterpretation.
>
> …
>
> It is my belief that if our staff had implemented correct routines for your mother initially, then her resulting pressure area could have been prevented or, at least, minimized. I agree that regular position changes are essential in such circumstances. Further, the non-reporting of the changes in the pressure area were unforgivable and the nurses involved in monitoring and dressing the area were negligent…"

Competency issues

The Nursing Council undertook a competence review of Ms E following a complaint made by another registered nurse at the Facility. The Council asked Ms E to undergo a programme of assessment and complete an examination set by the Council. In addition, she was to practise and administer medications only under the supervision of a nurse nominated

by the Council. Two other registered nurses employed at the Facility were required to undertake a competence review, and similar conditions were placed on their practice.

Actions by the Facility following review
The Care Manager position was discontinued by the Facility and an Assistant Manager Role was created. Ms E agreed to take a position as registered nurse in the facility but subsequently returned to the United Kingdom and is no longer nursing. Ms G terminated the contract of one registered nurse and re-employed others in different areas, at a reduced level of responsibility. Ms G explained that she subsequently employed two registered nurses, and the Facility has had an "almost complete change of senior staff" since these events. Ms G also spent a significant amount of time visiting the Facility for a period of four months "implementing systems and employing competent staff" in liaison with the Ministry of Health. The Facility was fully compliant with a Ministry of Health certification audit dated August 2006.

Independent expert advice

Expert advice from general practitioner Dr Ian St George is attached as **Appendix 1**. Nurse Jenny Baker's advice is attached as **Appendix 2**. Additional advice from Dr St George is attached as **Appendix 3**.

Responses to provisional opinion

The Facility
In response to my provisional opinion, Ms G acknowledged that the Facility did not provide an appropriate standard of care to Mrs A. She stated:

> "Whist I am reluctant to allocate blame, time and hindsight have led me to believe that the key issues in this case were the lack of adequate support and monitoring, at all levels, by the general manager and the unsatisfactory level of competence of several registered nurses. Since this event we now have a new and very competent general manager and none of the original registered nurses are employed by us … Our expectations of our staff are now communicated very clearly."

Ms G commented that there "has never been a problem" with providing appropriate equipment at the Facility. She stated that the company is proactive in ensuring the Facility is well-equipped. In addition, Ms G disagreed that the care planning templates needed review.

She advised that the certification auditors have "always been extremely complementary of these documents" and it is difficult to simplify them because of reporting requirements.

Ms E

Ms E said that she is no longer nursing as a result of this matter and the way she had been blamed for what occurred. She apologised to the family. She stated:

> "I am glad that my workload was highlighted and the policies of [the Facility]. I … hope lessons have been learnt. I know I made mistakes but I still feel I was used as a scapegoat by [the Facility]."

Ms E also provided a testimonial from another family, which observed that when they had complained about problems at the Facility "hospital management deflected our criticisms and blamed the staff".

Dr D

Dr D argued that he had a reasonable expectation that registered nursing staff in a hospital level facility would be aware of the risk of pressure sores and ulcerations in a physically disabled patient. The nurses had the responsibility for the daily provision of clinical care to Mrs A, and to liaise with other health professionals. Therefore, it is not his practice to document the necessity of suitable pressure cares when admitting a patient, "in the same way that I do not document the requirement for regular meals, bathing and toileting of patients …" all of which he reasonably expected a suitably qualified nursing staff to perform.

Dr D submitted that it is not the responsibility of the general practitioner to ensure that proper standards are met by other health professionals in the team caring for his/her patient. To place such a responsibility on the general practitioner would be to place an unreasonably high burden on general practitioners, requiring them to be qualified not only in their own field of expertise, but also in other specialty areas. He argued that in a rest home setting the team is multidisciplinary, and such a burden is unreasonable. He emphasised that nursing staff are autonomous in a rest home environment. He also submitted that the condition of Mrs A's pressure sore on 24 November was not sufficiently serious to warrant specialist intervention — and reiterated that he did indeed review the pressure area on this date. He said that there was a significant deterioration in Mrs A's pressure sore area between 24 November and Dr J's review on 1 December.

Dr D's lawyer, Ms F, submitted that although rest home care is multidisciplinary, the responsibility for assessing the effectiveness of multidisciplinary care does not rest with the general practitioner. She stated:

> "Importantly, [the Joanna Briggs Institute guidelines] do not state that the responsibility for assessing the effectiveness of multidisciplinary care rests with the general practitioner, as Dr St George [expert advisor] appears to state in his opinion."

Dr D disagreed that the earlier institution of dietary supplements would have prevented Mrs A's weight loss and skin breakdown. He considered that Mrs A did not receive sufficient caloric intake because of her limited ability to ingest food and/or supplements. Dr D also noted that dietary supplements were not provided to Mrs A by Hospital 2 specialist staff, and supplements were introduced as a result of his visit on 24 November. He stated:

> "[Mrs A] was an 82yr old woman who had a diagnosis of right cerebrovascular accident causing left hemiparesis, cognitive impairment and dysphagia. The patient was unable to maintain satisfactory nutritional requirements due to her stroke. The skin problems, pressure sores and ulceration, occurred because of poor nutritional intake causing low body weight, boney prominence and immobility. To have maintained satisfactory nutritional intake, [Mrs A] would have required artificial feeding (with nasogastric tube or parenteral nutrition). The accepted practice for a patient in this condition is to offer supportive care.
>
> …
>
> [Mrs A] could have been 'proactively' managed with a feeding tube or parenteral nutrition, but this approach is considered highly inappropriate in such a patient. It is accepted practice to manage such a patient conservatively, offering supportive care only."

Ms F submitted that the Best Practice Guidelines from the Joanna Briggs Institute referred to by Dr St George are guidelines for nurses, and are not mandatory clinical standards for general practitioners in New Zealand. Furthermore, Ms F submitted that a failure to meet "best practice" standards does not necessarily constitute a finding that care was below a reasonable standard.

Dr D disagreed with the inference that he was not suitably qualified to work in aged care facilities. He informed me:

> "I have completed the educational requirements for a Fellowship of the College some time ago and am awaiting the awarding of the Fellowship. I also participate in regular professional development requirements which cover geriatric work. I have over ten years experience in rest home care and I am able to present comments from the various homes I have worked in to attest to my expertise. It may be confirmed with the RNZCGP [the Royal New Zealand College of General Practitioners] that I am suitably qualified to be entitled to do rest home work."

In addition, Dr D was concerned that my advisor, Dr St George, assumed from his medical notes that his contact with Mrs A was brief. Dr D stated that the length of his consultations cannot be assumed on the basis of his notes regarding Mrs A's sacral area.

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

Right 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

Opinion

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

Opinion: Breach — The Facility and Ms E

Introduction

Mrs A was admitted to the Facility in the early hours of 28 October 2005 with vulnerable skin and a known risk of sacral pressure sores. She required feeding and had difficulty swallowing. The Facility requested that staff turn her every two hours but did not provide specialised pressure area equipment until 1 December, the day after Mrs A had been referred for outpatient treatment for a necrotic and infected pressure sore. She lost approximately 10kg of weight during her six weeks at the Facility. Overall, it is clear that Mrs A was not appropriately assessed, monitored and treated while at the Facility. To a large extent, the deterioration of her pressure sore occurred during Care Manager Ms E's absence. The level of competency of some registered nursing staff caring for Mrs A during this period has proven to be substandard. However, significant concerns with the overall management of Mrs A's care have also been identified. I consider that the failings in Mrs A's care illustrate serious systemic deficiencies at the Facility at the time of her residency there.

The Facility has acknowledged that the care Mrs A received was substandard and a breach of her rights under the Code. Since these events, significant effort has gone into improving systems at the Facility (in consultation with the Ministry of Health) and there have been extensive staffing changes. I commend the Facility for their efforts to improve their systems and services subsequent to this case. Nevertheless, in reviewing the care provided to Mrs A

between October and December 2005, it is my opinion that the Facility breached Right 4(1) of the Code. The reasons for my view are set out below.

Pressure area care

Immobility creates the risk of pressure areas for all patients, and diligent care is required to prevent sores. The Facility's Pressure Area Care policy highlighted these risks and the need to assess and prevent pressure areas. Mrs A's risk of pressure sores was drawn to the attention of the Facility in the Hospital 2 referral information on her admission to the Facility. The assessment documentation completed by registered nurse Ms J noted that two hourly turns were required. Ms J also partly completed a pressure sore risk assessment giving Mrs A a Waterlow score of 13. This denoted a patient at risk of developing pressure sore areas. The information suggests that if the assessment had been completed, Mrs A would have been in a higher risk category. She was given no score for skin appearance or special risks. My expert nurse advisor, Ms Jenny Baker, calculated Mrs A as being at very high risk.

Later on the day of admission, Ms E completed the care planning documentation and instructed staff to turn Mrs A two hourly (on the short-term care plan) and four hourly at night (on the resident lifestyle plan). Ms E said that Mrs A's pressure area was covered with a protective dressing from the time of admission, although there is no documentation to confirm that this occurred. Ms B has expressed concern about whether her mother was turned according to the plan but there are regular references in the clinical records to two hourly turning.

It is difficult to obtain a clear picture of the deterioration of Mrs A's pressure area. On 3 November the resident report form documents that the sacral area was not improving. Staff were instructed to turn Mrs A two hourly (as already required under the care plan). On 7 November, two wound charts were commenced. From this juncture onwards, it is apparent that Mrs A's pressure sore areas should have been treated and monitored according to the Facility's Wound Care policy. One wound chart recorded a superficial sacrum wound of 2cm diameter (reviewed on 10 and the 22 November). The second wound chart for 7 November describes a small sacrum wound with a "broken" and "sloughy" area (reviewed on 24 November).

My expert nursing advisor, Ms Jenny Baker, stated:

> "The wound charts do not clearly assess or identify the initial areas or changes in the areas, nor do they identify appropriate wound dressings. It is important to carefully assess the pressure areas including whether sloughy, necrotic, depth and size of wound, whether exudating or dry, infected or clean in order to identify the appropriate primary and secondary dressings."

While the charts were inadequate, the pressure area had clearly deteriorated sufficiently to be regarded as a wound prior to Ms E's period of leave (17 November to 6 December). Yet there is no evidence that Mrs A's pressure sore was appropriately monitored in Ms E's

absence. Neither Ms H (who had overall responsibility for the hospital wing) or Ms I (who undertook an informal oversight role) were alerted to any urgent concern about the pressure sore. They both relied on advice from registered nursing staff, who did not appear to have been given any particular direction, and did not report any concern about Mrs A's pressure sore. Clearly the monitoring of, and response to, Mrs A's pressure sore by staff at the Facility was inadequate, and unacceptable.

Pressure area equipment

Mrs A was given an air-filled mattress while at Hospital 2. However, she was provided with a basic pressure-relieving mattress (the Apollo) on admission to the Facility. The Apollo is designed for individuals with a "medium risk of developing pressure sores". As previously discussed, my expert has advised that Mrs A should have been assessed as being at high risk. Mrs A's pressure area and the adequacy of her mattress were discussed at a family meeting on 14 November. However, Ms E incorrectly understood that any further pressure-relieving equipment needed to be provided by Mrs A's family. Ms E also expressed the view that it was difficult to obtain management approval for the purchase of additional items, and that the mattress provided was felt by the management to be adequate for all pressure area needs.

On 21 November, the district health board physiotherapist strongly advised Ms B to liaise with the Facility to obtain high pressure-relieving equipment. The progress notes on 22 and 23 November clearly record an ulcer with broken skin. On 24 November, general practitioner Dr D directed the Facility staff to monitor the sacral ulcer (see discussion *below*). A family meeting also occurred on 24 November with the Care Manager of the Dementia Unit, Ms I, and it was agreed that the pressure sore care would be reviewed. Despite this, Mrs A did not receive an air pressure mattress (and cushion) until around 1 December. This is unacceptable.

The Facility's Pressure Area Care policy states that all specialised equipment will be used to reduce the risk of deterioration of pressure areas. This was not complied with. My advisor considered that this equipment should have been provided, at the latest, around 23 November when the development of an ulcer was documented. If Mrs A's pressure sore risk assessment had been completed on admission, her need for a different mattress would have been obvious even earlier than this. Ms Baker stated:

> "The Apollo mattress is not designed for this type of risk and should have been replaced with a higher pressure relief mattress as soon as [the Facility] were able to obtain it; this should have been obtained within the first week. In the event that [the Facility] management was unable to recognize the need for a higher pressure relief system at the time of [Mrs A's] admission, a higher pressure relief system of mattress and cushion should have been provided as soon as [Mrs A's] sacral area became a stage 3 pressure area."

Nutrition

On admission to the Facility it was noted that Mrs A had previously weighed approximately 53kg. The Facility's Nutrition policy required residents to be weighed on admission. This was not done, apparently because Mrs A was unable to stand and had poor sitting balance. However, my advisor considered that Mrs A should have been weighed within 24 hours of her admission, and this could have been done with two staff members transferring her to the sitting scales. I agree with my advisor that the failure to weigh Mrs A on admission (and lack of weight chart) made it difficult for staff (and Dr D) to alert themselves to the extent of Mrs A's weight loss.

Due to her stroke, Mrs A was unable to feed herself, had a reduced ability to swallow, and required to be fed upright. In addition, swallowing food would have been more difficult owing to her ongoing (and apparently poorly managed) oral thrush. There are a number of inconsistencies in the documentation of Mrs A's nutritional needs. The Facility assessment documentation noted that a normal or soft diet was required. In contrast, the Hospital 2 referral information stated that Mrs A required a soft or puréed diet. Ms E documented that dietary supplements were required (in the lifestyle plan completed on admission). However, there is no indication that supplements were provided. An additional note on 14 November states that "nutritional supplements were required". This note was made after specific concern was expressed by Mrs A's family about her nutrition. Again, there is no documentation to show that any dietary supplements were provided. Ms E has acknowledged that she "forgot" to institute dietary supplements before going on leave on 17 November. One can only conclude that registered nursing staff did not regard the lifestyle plan as a definitive guide to patient care.

When Mrs A was eventually weighed on 21 November as 45 kg, her significant weight loss (8kg since the last recorded weight) should have prompted a dietician referral and commencement of dietary supplements such as Ensure. No action was taken in response to Mrs A's visible weight loss until after Dr D's review of 24 November and the family meeting with Ms E on the same date. A plan was documented on 25 November for weekly weighs and a referral for nutritional supplements. However, it appears that nutritional supplements were not actually provided until 1 December after Mrs A had lost a further 3.5kg. (An application for Ensure was eventually made on 6 December but it is recorded that she was given some on 1 December, and from 4 December.)

My nursing advisor considered that Mrs A clearly required nutritional supplements soon after her admission. She stated:

> "The Registered Nurses should have assessed [Mrs A] as requiring nutritional supplements based on her weight loss, poor appetite, pressure areas, etc. They are health professionals and should be proactively assessing and caring for [Mrs A] and not just responding to her daughter's requests. It is unacceptable that no action was taken by [the Facility] staff until requested by the daughter and then told to by [Dr D]."

I agree with my advisor that the Facility's response to Mrs A's weight loss and nutritional needs was inadequate.

Medication administration and pain relief

Mrs A's regular medications were generally administered as directed but not all medication was signed for and there were several discrepancies with this aspect of her care. In particular, it is not clear whether she received her medication for oral thrush (Nilstat Oral suspension) prescribed by Hospital 2 (as this condition did not resolve) and the multivitamins prescribed by Dr D on 23 November were not dispensed until 4 December. It is also unsatisfactory that there was no formal assessment and management of her pain levels by registered nursing staff. Mrs A was eventually provided with regular pain relief at Ms B's insistence. The medication system used at the Facility was clearly inadequate and did not provide a record of any amendments to a patient's medication regime.

Documentation

The registered nursing staff had primary responsibility to ensure all documentation was completed at the end of each shift. The Resident Care Planning and Monitoring policy required "full" contemporaneous progress notes to be completed by care staff. However, the daily progress notes were updated on an irregular basis, with very few entries from caregiver staff. It is a significant oversight that from 25 November until 1 December 2005 there were no entries recorded in Mrs A's daily progress notes by any nursing or care staff. Caregiver staff regularly completed the Daily Resident Review form, which provided a tabulated summary of a resident's care. However, this form does not allow for a comprehensive and detailed description of the care provided. Ms Baker considered that the level of documentation that occurred on a daily basis was substandard. Ms Baker also drew attention to incomplete and inaccurate assessment and planning documentation. She stated:

> "The level of documentation in [Mrs A's] progress notes is very poor for a hospital and I would expect documentation to occur on every shift by the caregiver and as required by the Registered Nurse. I would expect that the Registered Nurses ensured the progress notes were documented in at the end of every shift; caregivers should not leave work until they have done so for all their residents."

In an environment such as a rest home, where care is provided by a number of caregivers, adequate and accurate notes are vital to ensuring that areas of concern are regularly monitored and changes in condition can be readily noted and actively responded to. This is a key factor in ensuring effective co-ordination and continuity of care in multidisciplinary environments. The documentation of Mrs A's condition fell well below the required standard of care in this case.

Conclusion

As Care Manager, Ms E was responsible for the overall management of the Facility's hospital wing and the supervision of nursing staff. However, it is clear that she also fully involved herself with daily nursing activities. The documentation shows that Mrs A had

developed a pressure sore area, albeit relatively superficial, prior to Ms E's period of leave from 17 November. Ms E was aware of this, and she commenced a wound chart on 7 November. She met with Mrs A's family on 14 November to discuss their concerns. Unfortunately, Mrs A was not provided with a higher grade of pressure mattress following this meeting. Clearly, the provision of specialised pressure area equipment should have been considered at this juncture given the family's concern and the potential for deterioration. During the time Ms E was on leave there was a significant deterioration of Mrs A's pressure sore. The Facility should have provided pressure-relieving equipment, at the very latest, around 23 November when there was evidence of a worsening pressure sore.

The importance of prevention in pressure area care cannot be underestimated. Optimally, specialised pressure equipment would have been provided after a full assessment of Mrs A's risk on her admission. Hospital 2 had provided Mrs A with an air mattress to reduce the risk of pressure sores, and this was documented in the referral information. Overall, I do not consider that Mrs A received an adequate assessment on admission. This omission was then compounded by subsequent events. In the circumstances, I am unable to accept Ms G's assertion that the Facility was proactive in providing appropriate equipment.

The registered nurses failed to undertake appropriate monitoring and care of Mrs A's pressure sore, particularly when Ms E was on leave. Furthermore, there was also a general failure to respond to Mrs A's significant weight loss. Other aspects of Mrs A's overall care, such as medication administration, pain management and the treatment of her oral thrush were not optimal. The documentation of her care was patently inadequate.

My expert nursing advisor, Ms Jenny Baker, observed that some of the inadequacies with Mrs A's care may have occurred because of Ms E's workload, the apparently minimal support she received from management, and the level of competency of her staff. I accept this. I also note that a number of different registered nurses and caregiver staff were involved in Mrs A's care. Nevertheless, as Care Manager, Ms E had overall responsibility for the management of Mrs A's care, and the nurses were under her supervision. Ms E should have taken a more proactive approach to the management of Mrs A's pressure sore. She should have put measures in place to monitor Mrs A's weight and ensure that she received dietary supplements. In all the circumstances, I am not satisfied that Ms E provided adequate care to Mrs A.

Ms E was an inexperienced Care Manager at a new facility. She was responsible for implementing and maintaining safe care practices and providing appropriate and safe care to residents. However, she appears to have been provided with relatively limited support by management to implement the relevant policies, some of which were conflicting. This was unsatisfactory, and appears to have contributed to Ms E's ineffective management of the hospital wing, and the failure to provide Mrs A with specialised pressure relief equipment, and appropriate care.

There is nothing to suggest that the Facility provided any meaningful supervision or support for its registered nurses during the absence of Ms E. There were apparently no formal arrangements for cover or even direction as to what should occur. Ms H's involvement appears to have been minimal, although she had overall responsibility for the hospital wing. It appears that the registered nurses were left to carry out the daily nursing tasks, with Ms I being involved on an occasional basis. To an extent, the Facility were entitled to rely on the competency of registered nursing staff. However, given the known concerns about Mrs A's care (from her family), the known development of a pressure sore, and the concerns about the competency of several staff members, a higher degree of direction, supervision, and oversight of the registered nursing staff was required. It was not sufficient for Ms H to obtain an occasional verbal assurance from nursing staff that all was well. Furthermore, any concerns about the ability of nursing staff to undertake their duties should have been promptly addressed.

It was the responsibility of the Facility, and Ms E, to ensure Mrs A was appropriately assessed and managed. Ms E clearly undertook too much daily nursing work and, most crucially, failed to provide effective clinical oversight to her staff. Despite the involvement of many different staff, there was a significant failure to respond to Mrs A's deteriorating pressure area and her weight loss. As an organisation, the Facility failed to develop and maintain appropriate systems of care. A contributory factor appears to have been a lack of understanding amongst key staff as to the precise nature of their responsibilities, including daily tasks and supervision of other staff. As Ms G has acknowledged, there was a lack of adequate support and monitoring provided to patients and staff at all levels at the Facility. In these circumstances both Ms E, and the Facility, failed to provide an appropriate standard of care to Mrs A and breached Right 4(1) of the Code.

Opinion: Breach — Dr D

31 October 2005 assessment — pressure area and nutrition management

Mrs A was initially seen by general practitioner Dr D at the Facility on 31 October. Mrs A's Hospital 2 medical records were not available to Dr D at this time. However, he had access to the referral information and the Facility's assessment documentation, both of which refer to Mrs A's sacral redness. Nevertheless, Dr D advised that he was not aware that Mrs A had a sacral pressure area at this visit. Accordingly, he did not examine Mrs A's sacral area, and did not alert himself to any potential problems. Dr D expected that if there were concerns regarding Mrs A's skin condition or nutrition, they would be monitored by the nursing staff, who would draw his attention to them if required. Dr D regarded Mrs A as stable and planned to review her three monthly, unless an earlier review was requested by the Facility nursing staff.

My expert general practitioner advisor, Dr Ian St George, agreed that the management of pressure areas and nutrition was a nursing responsibility, and nurses would be expected to alert Dr D of any concerns regarding Mrs A's condition. However, Dr D was not working in isolation. I do not accept Dr D's argument that nursing staff provide autonomous care in the rest home environment. He was a member of a multidisciplinary clinical team caring for Mrs A and, as such, had a responsibility to ensure the team worked cohesively to deliver appropriate care to Mrs A. This does not mean he had a duty to "supervise" the nursing staff to the extent of ensuring that personal cares had been undertaken. It did mean he had a responsibility to ensure that proper standards of care were being maintained in the care of Mrs A, not just by himself, but by the clinical team as a whole. This includes satisfying himself that there had been adequate discussions and assessment of Mrs A's nutritional needs and that pressure area care occurred across the team. I agree with my advisor that this is a responsibility that applies to all members of the multidisciplinary team.

As Dr St George noted, teams may be egalitarian, but the members are interdependent, and that dependency requires good communication. Team members must work together to deliver cohesive services of an appropriate standard. When members start working in isolation and fail to communicate effectively with each other, important care issues can be missed, as happened in this case.

Dr D's lawyer, Ms F, challenged my advisor's reference to the Joanna Briggs Best Practice guidelines (the guidelines). In particular, she is concerned that the guidelines represent best practice rather than reasonable care and do not state that general practitioners have "responsibility for assessing the effectiveness of multidisciplinary care". As Dr St George has explained, the guidelines encapsulate good standards of patient care. Overall, I am satisfied that Dr St George, a highly experienced general practitioner, has provided an appropriate description of the role of a general practitioner with respect to the multidisciplinary team. Furthermore, I note that in opinion 04HDC07008 the Commissioner was also of the view that the general practitioner was a key part of the multidisciplinary rest home team and his responsibilities went beyond the prescribing of medication. [20]

Clearly, Mrs A was a vulnerable patient who required careful pressure area and nutrition risk assessment. The fact that these risk assessments were required to be performed by registered nursing staff under the Facility's policies does not excuse Dr D from his responsibility to ensure that Mrs A was receiving the care that she required. At the very least, these matters should have been discussed with the nursing staff on the date of Dr D's initial assessment. I have found the Facility responsible under the Code for failing to ensure the team provided services to Mrs A with reasonable care and skill. Dr D must also bear responsibility for his role in the team's failure in this regard. In my view, Dr D should have examined Mrs A's pressure area at this visit and requested that her weight be monitored. He

[20] In opinion 04HDC07008 the Commissioner was critical of a general practitioner for not enquiring further about the extent of a rest home resident's behaviour after being notified of an episode of possible sexual abuse.

should also have requested that the relevant information from Hospital 2 was forwarded to him when it became available. I am satisfied that a reasonable practitioner in these circumstances would have at least documented Mrs A's risk and discussed it with the nursing staff. There is no evidence that Dr D did this.

24 November assessment — pressure sore management

Dr D examined Mrs A again on 24 November, at the request of her daughter, who was concerned at her deterioration and the care she was receiving at the Facility. I am faced with conflicting accounts of this consultation. On the one hand, Ms B states that she was present at the consultation, and that Dr D did not undertake an examination of Mrs A's sacral area despite her request. Ms I was concerned about Dr D's response to her mother's evident weight loss. On the other hand, Dr D maintains that Ms B was not present at the consultation. Although the medical notes do not contain a description of the condition of Mrs A's sacral pressure area, he states that he did examine the area, and although he considered specialist referral and discussed it with Mrs A's other daughter, Dr C, he did not consider specialist referral was warranted at that time. In making this decision, he was cognisant that Mrs A was due to be reviewed by a hospital rehabilitation specialist in approximately six days' time. Dr D concluded that it was reasonable to attend to the pressure area at this time through nursing care, and he discussed Mrs A's management with Ms I. He advised that his notes also show that nutrition was discussed, with the instruction for weekly weighs and consideration of dietary supplements.

It is clear from the notes that Dr D did consider Mrs A's nutritional status at his review on 24 November, and provided instructions to the nurses for regular weighs and nutritional supplements. However, on the information available, I am unable to reconcile the conflicting accounts of Dr D's examination of Mrs A's sacral wound on 24 November. In any event, I am not convinced that Dr D took sufficient action on 24 November to stop the wound deteriorating further. If Dr D did examine the sacral area, I am concerned at the lack of documentation and response to the deteriorated condition of her sacral area. At the very least, the condition of the ulcer should have been noted. This is particularly so given the notation in the progress notes the day before by the RN on duty that the broken skin around the sacral area had developed into an ulcer. Dr D himself noted in his correspondence to me that there had been a significant deterioration of the pressure area at this time. If Dr D did not examine the sacral area, he clearly should have done so on the information available to him. A failure by him to do so would also fall below the provision of appropriate care to Mrs A. If Dr D did not examine the pressure area on 24 November, no doctor sighted the area until Dr J reviewed it on 30 November, by which point urgent medical intervention was required.

While, as noted above, the supervision of the Facility nursing staff was not Dr D's responsibility, even a cursory glance at the daily progress notes would have revealed that Mrs A was not being appropriately monitored. The degree of deterioration of her pressure sore evident from examination or, if he did not examine her, from the description in the notes

from the RN the day before, should have been a warning sign to Dr D. I consider that Dr D should have requested a higher level of pressure-relieving equipment for Mrs A and considered a more urgent proactive response to her deterioration. While I note his reasons for not making a specialist referral at that time, in my view it was not sufficient to wait for Mrs A's scheduled appointment with the rehabilitation registrar, which was expected to be on 1 December (and was undertaken by Dr J on 30 November) given the potential for pressure ulcers to deteriorate rapidly if not appropriately managed. Dr D should have been much more proactive with arrangements for managing Mrs A's deteriorating sacral pressure area. His failure to do so was, in my opinion, a failure to provide Mrs A with care of a reasonable standard.

Conclusion

Overall, I do not consider that Dr D provided Mrs A with an adequate standard of care during his assessments on 31 October and 24 November 2005. The care he provided was reactive when a proactive approach was required. Accordingly, it is my opinion that Dr D breached Right 4(1) of the Code.

Other Comment

Policies and procedures

Ms Baker advised that the policies and procedures at the Facility were detailed but "not completely adequate" and contained conflicting information. For example, the Care Manager's job description states that the role entailed overall responsibility for the hospital, with supervision of the daily nursing activities carried out by registered nursing staff. The registered nurse job description states that nursing staff have responsibility for daily nursing care including assessment, reassessment and care planning. However, the Resident Care Planning and Monitoring policy makes the Care Manager responsible for residents' assessments. The policies require clarification, particularly with regard to the allocation of responsibilities and linkages with associated policies and job descriptions. Ms Baker observed:

> "The policies state procedures but are not clear as to how the staff carry out some procedures such as accessing alternative pressure relief systems. The Resident Assessment, although detailed, is unwieldy and user unfriendly. The Lifestyle Plan does not meet long term care plan requirements and is also user unfriendly. The wound chart is inadequate as an assessment and management tool. There are no separate assessment tools for staff to assess/reassess as residents' needs change. The Medication Administration Record does not detail medications in the pack."

As Ms Baker noted, the Facility's policy documentation was ambiguous as to the allocation of responsibilities. Dr Ian St George has also observed that the policies did not clearly differentiate areas of responsibility.

Ms G disagrees with Ms Baker's criticisms of the Facility's care planning documentation. However, I am not convinced that the care planning forms were adequate. Although the care planning templates may be sufficiently detailed, they do not present as being particularly easy to use. I also note that on several occasions, entries made in the care planning documents did not result in recorded action. In addition, there was conflicting information in the care plan and lifestyle plan with regards to care requirements. Ms Baker also noted that the lifestyle plan should not have been developed for a further three weeks, to allow time for Mrs A to be fully assessed and for other information, such as physiotherapy and medical assessments, to be included.

Actions taken

As noted above, considerable effort has gone into improving systems and the competency of staff at the Facility since these events. Ms G also liaised with the Ministry of Health (MOH) and District Health Board 3 in relation to improvements at the Facility. On 6 August 2006, the MOH informed me:

> "[Ms G] has also provided the Ministry with written reports of the progress being made in her implementation to an agreed plan to address the issues that have been raised. These issues included:
>
> - Revising senior and middle management structures (including the Care Manager and registered nurses);
> - Review and amendments to the roles and responsibilities of these positions;
> - A more structured programme of staff training for all levels of staff;
> - Improving record keeping and report writing;
> - Improving communications within the facility between registered nurses;
> - Regular internal auditing eg client records;
> - Meetings with the general practitioners and improving communications with GPs by one staff member being responsible for non-urgent requests;
> - Holding regular family meetings to explain changes being made.

> A physical inspection of the facility shows that it is a modern building equipped with good facilities that would be appropriate for care of persons who have suffered strokes.
>
> The facility has a good range of equipment available and if an item required is not available then it can be hired from a medical equipment company.
>
> Although [Ms G] regularly visited and spent time at [the Facility] she has since early June devoted up to four days each week at the facility to ensure that these changes are happening. She stated that she is likely to continue this programme until the end of August after which she will reduce her prolonged weekly commitment to visiting, but that she will still regularly have a presence at the facility.
>
> The Ministry is continuing to keep in touch with [Ms G], and at this stage we are satisfied that the programme that is in place will address the issues that have previously been raised."

I also note that the Facility's medication administration systems have since been reviewed, in conjunction with the Facility's pharmacists, to ensure there are clear patient medication records.

Recommendations

I recommend that the Facility take the following actions:

- Further review systems of care at the Facility in light of my report, and report back to me by **7 February 2008** on steps to be taken to address the issues that have been highlighted.
- Consider whether the current policy documentation requires review to ensure that the roles and responsibilities of staff are clear and policies are compatible.
- Apologise to Mrs A's family for its breach of the Code.

I will also ask that the Ministry of Health (HealthCert) include an audit of pressure area and nutritional assessments, the quality of residents' progress notes, and the forms and templates used by staff, in the next scheduled audit of the Facility.

I recommend that Ms E and Dr D take the following actions:

- Apologise to Mrs A's family for their breach of the Code. This apology is to be sent to this Office and will be forwarded to Mrs A's family.
- Review their practice in light of my report and the comments of my experts.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, and the New Zealand Medical Council.
- A copy of this report, identifying only the Facility, will be sent to the Ministry of Health and District Health Board 3.
- A copy of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners, the Retirement Villages Association of New Zealand and HealthCare Providers New Zealand, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1

The following expert advice was obtained from general practitioner Dr Ian St George:

"1. ***Request***

I respond to your letter of 12 February 2007 seeking advice in relation to [Ms B's] complaints against [Dr D]. I am asked to provide independent expert advice about whether general practitioner, [Dr D] provided an appropriate standard of care to Mrs A.

2. ***Background*** (as you have related it to me)

…

5. ***I have assessed*** whether the doctors' actions were reasonable in the circumstances by the standards of the profession, as far as they have been stated or previously judged, at the time of the incidents. I state here I have no personal, financial or professional connection with any party that could bias my assessment.

I note the conflicting accounts of some matters — whether [Ms B] was present on 24 November, whether [Dr D] refused to perform some examinations — and state here that I am not in a position to assess the credibility, from the papers, of either account.

In my opinion

- [Dr D] provided services of a barely adequate standard to [Mrs A].
- The division of clinical care and responsibility must be clearly understood by doctor, nurses and management; [Dr D] quite properly states that the management of pressure areas is a nursing responsibility; the nurses in turn would be expected to alert the doctor of concerns. However, he was a member of the clinical team, and the team was caring for a vulnerable patient, and they should have been discussing nutrition and pressure area care.

The clinical standards that apply are those of good clinical management of nutrition and pressure areas in vulnerable patients. While the New Zealand Guidelines Group and BPAC have not developed such standards, they are well known, and can be found easily in documents from other countries — for instance UK (National Health Service NHS: PressureAreaManagementGuidelines.pdf, and National Institute for Clinical Excellence (NICE) http://www.worldwidewounds.com/2001/july/Butcher/NICE-pressure-ulcer-review.html; and Australia:

http://www.joannabriggs.edu.au/best_practice/bp1.php.

- All of these guidelines identify patients at high risk, and list actions that should be taken to reduce the risk.

- For instance (from the Australian website above), **'Recommendations for assessing the risk of developing pressure sores':**

  - Any patient with a mobility or activity deficit should be subject to a risk assessment.
  - A judgement should be made as to the patient's classification in one of the following categories: not at risk, at risk, at high risk.
  - Assessment should occur on admission to the unit, following a significant clinical event or change in condition, and at regular intervals for the long term patient.
  - Clinical variables to be considered in the assessment should include mobility, incontinence, nutritional status and neurological status.
  - Risk assessment tools such as the Braden or Norton Scale provide a valuable supplement to clinical judgement especially for inexperienced staff.

And, 'Recommendations for the care of skin':

Assessment:

- The skin of the 'at risk' patient should be inspected on admission and at least daily.
- Inspection should also be made after prolonged procedures that involve reduced mobility and hardened surfaces, for example lengthy radiological examination.
- Pressure points over bony prominences should especially be examined for persistent redness or other discolouration.
- Any skin change should be documented and the area given particular intervention.

Hygiene:

- Comfort alone dictates that skin should be cleansed when exposed to bodily fluids or other soiling; it is particularly important for the at risk patient. If frequent soiling occurs action should be taken to control the source of moisture, for example continence management.

Moisture management:

- Harsh cleansing agents should be avoided as they may irritate and dry skin. Moisturisers are helpful for dry skin.

Nutrition:

- Nutritional assessment of the 'at risk' patient should be performed on admission and diet should be monitored. Recent involuntary weight changes, loss of appetite

and reduced dietary intake are obvious indicators of nutritional problems. Where possible oral intake should be encouraged with nutritional supplements if necessary. If oral intake remains insufficient more assertive nutritional measures may be required.

And 'Recommendations for pressure-relieving interventions':

- Turning is useful in rotating pressure prone areas. Frequency should be based on skin inspection. The frequency should be increased if skin discolouration persists.
- Positioning should avoid direct pressure on bony prominences.
- Pillows and foams should be used to reduce contact between bony prominences and support surfaces.
- Massaging of bony prominences and the use of doughnut shaped devices should be avoided.
- Bed heads should be no higher than the lowest elevation.
- Lifting devices and aids such as sail cloth should be used to reduce friction when moving patients.

And 'Recommendations in the use of support surfaces':

- The use of specialist support surfaces should be considered as part of an overall plan.
- In patients assessed as 'at risk' of developing pressure sores, a low pressure support at least should be used rather than a standard hospital mattress.
- Patients assessed to be at 'high risk' should be placed on a dynamic device such as a large cell alternating pressure mattress or a low air loss or air fluidised bed.

It was [Dr D's] responsibility to ensure that proper standards were being maintained, not just by himself, but by the other health professionals in the team caring for his patient.

He did not document a full assessment of [Mrs A's] risk, nor did he ensure further risk was minimised (by monitoring her weight and ensuring prompt nutritional supplementation, by insisting on a proper weight-distributing or air mattress, for instance), nor did he (until late) examine her pressure areas himself, and so did not recognise the formation of an ulcer and did not refer her appropriately. These inactions can to an extent be understood by his appropriate perception that the policy stated these were nursing duties, but they do fall short of what should be expected of a leader of a clinical team. His documentation of his encounters with [Mrs A] also fall short of the ideal, but they may accurately portray the brevity of those encounters.

His peers should, I think, view his actions as a mild to moderate departure from the usual standard of care.

That having been said, [Dr D] is not vocationally registered, so presumably has not undertaken formal vocational education for general practice; but even if he had, this kind of care is very different from day to day general practice, and requires a different set of knowledge, skills and attitudes. That set of knowledge, skills and attitudes should be acquired by any doctor who accepts this kind of work — and the Goodfellow Unit at Auckland Medical School offers a geriatrics/gerontology course by distance learning. Aged care facilities should insist their medical staff are adequately prepared.

'[The Facility's] Director, [Ms G], places the blame squarely on staff employed at that time, but no longer employed there. That may be reasonable, but at the very least, questions must be raised about their policies differentiating nursing from medical risk assessment and surveillance of pressure areas, the clinical staff they employ — doctors and nurses — and the communication of systems and responsibilities, as well as clinical observations, among the staff. [Ms G's] claims about the foam mattresses also suggest a lack of knowledge of that subject.

Ian St George"

Appendix 2

The following expert advice was obtained from specialist nurse Jenny Baker:

> "I have been asked to provide an opinion about the standard of care that [Mrs A] received while at [the Facility] in relation to the following questions:

…

Professional Profile

I registered as a Registered Nurse in 1978. From 1978 to 1981 I worked as a Staff Nurse in Oncology. From 1981 until 1995 I worked as a staff nurse in acute wards, initially in medical wards and then in continuing care (post children) and then across all acute wards at Wairau Hospital. In 1995, I was Clinical Nurse Co-ordinator in an Assessment, Treatment and Rehabilitation Ward (A, T & R) before taking up the position of Unit Manager, A, T & R Unit, The Princess Margaret Hospital. I then held the position of Nurse Manager of a 99 bed private hospital for Aged Care. This included a Dementia wing, and palliative and young disabled residents. From 2002 to 2004 I worked as a Nurse Consultant providing documentation development and implementation for the Health and Disability Standards Certification and the Ministry of Health Contract. I also provided general consulting advice and training for both staff and managers. This was primarily with Aged Care facilities nationwide. During that time I kept my clinical skills current by working as an Agency Nurse in both the Public and Private sectors. From 2003 to 2004 I was a Lead Auditor for a Designated Auditing Agency against the Health and Disability Standards Certification. From 2004 until 2005, I worked as a National Quality and Training Manager for a company who owned retirement villages with rest homes and hospitals nationwide. I currently work as a Care Manager in a rest home and rest home dementia. I have provided expert advice to the Health and Disability Commissioner in the Aged Care area since 2002.

Background

[Mrs A] was admitted to [the Facility] on 27 October 2005 late in the evening as a result of a bed crisis at the [Hospital 2]. The accompanying documentation from [Hospital 2] was brief and the second page of the nursing referral appears not to have been sent with [Mrs A].

At the time of [Mrs A's] admission to [the Facility], she had required two people to mobilize and required pressure area care. She had compromised skin integrity, a reddened sacral area and was at risk of developing pressure areas. [Mrs A] had a very poor swallow, required feeding, had oral thrush and was at risk of malnutrition. [Mrs A] was not weighed on admission to [the Facility].

During November 2005, [Mrs A's] skin integrity worsened and she developed two pressure areas which became necrotic and infected. Concerns were raised during this time by [Ms B], her daughter, in relation to pressure relief equipment, nutrition and adequate pain relief. [Mrs A] was under the care of [Dr D]. On 30 November 2005, [Mrs A] was seen by [Dr J], Registrar for Rehabilitation Services at [DHB 3]. [Dr J] urgently referred [Mrs A] to the plastic clinic where she was seen on 2 December 2005. Pressure relief equipment was not supplied by [the Facility] during this time. Some dietary supplements were given to [Mrs A] during late November prior to the official application for Special Authority from HealthPAC. [Mrs A] was transferred to another hospital on the 9 December 2005.

1 Was the care provided by [Ms E] adequate and appropriate?

[Ms E] was employed as the Care Manager for the hospital wing at the time of [Mrs A's] sojourn at [the Facility]. The Care Manager job description sets out the following requirements: Under Quality Management: *'Ensures that an excellent quality of resident care is provided by: a) Setting and maintaining safe care practices. b) Promoting optimum health of residents whilst maintaining respect, privacy and dignity … d) Providing appropriate, individualized culturally safe care and seeking outside support if necessary … g) Ensuring effective consultation with GPs, other health professionals and agencies are maintained'.* Under Staff Management: *'a) Ensuring competent and suitably qualified staff are available to meet the needs of the residents'.*

[Ms E's] role was that of overall responsibility for the hospital wing, to ensure that residents received the care they required and that the staff were competent and suitably qualified to meet those needs. The daily delegation and supervision of any nursing care related activities were the responsibility of the Registered Nurses on each shift. The Registered Nurses were also responsible to inform [Ms E] of any concerns they may have about a resident. [Ms E's] role did not require her to undertake assessments and care planning for residents.

The Resident Care Planning & Monitoring Policy dated 10/01/05 states: '*A registered nurse or Care Manager will visit all new residents within 24 hours of their admission in order to develop a short term care plan … Within 72 hours of a resident's admission a Care Manager will complete a Resident Assessment form. This is a comprehensive document that will provide sufficient information on which to base a long term Lifestyle Plan … It is the responsibility of the registered nurse to sign off the Lifestyle Plan … In developing the Lifestyle Plan the registered nurse will consult with the resident, the resident's family and staff as appropriate'.* The policy clearly defines responsibility for signing off the Lifestyle Plan as being the registered nurse and implies it is the registered nurse's responsibility to develop: *'In developing the Lifestyle Plan the registered nurse will consult with the resident …'* The policy conflicts with the Care Manager job description, and that

of the Registered Nurses, as it defines the responsibility for developing the Short Term Care Plan as being that of either the Care Manager or Registered Nurse with the Care Manager being solely responsible for the completion of the Resident Assessment form within 72 hours of admission. I find this policy to be confusing and it does not promote continuity by ensuring the same Registered Nurse or Care Manager completes all aspects of the assessment and care planning for the long term care plan, which is desirable.

In this instance, the Resident Assessment Form was partially completed by the night Registered Nurse, [Ms J], at the time of admission; [Ms E] apparently did not check this assessment form was completed fully when she presumably used it as the basis for the Lifestyle Plan development. [Ms E] developed the Short Term Care Plan as per her responsibility under the Resident Care Planning & Monitoring Policy. However she also developed both the Lifestyle Plan and the original wound charts; she is not required to do so under either under her job description or the policy's requirements. Clearly by [Ms E] completing the Lifestyle Plan this gave continuity to [Mrs A's] assessment and care planning, however, by undertaking the added responsibility of developing the Lifestyle Plan in addition to her own job description responsibilities and those outlined in the Resident Care Planning & Monitoring Policy, [Ms E] placed herself under additional and unnecessary pressure.

The Short Term Care Plan was developed on 28 October 2005, within 24 hours from admission and documented '*Pressure sore on sacrum 2 hrly turns'*. The Lifestyle Plan was developed on 28 October 2005 and documented under Sleeping: *'Requires turning — Yes Frequency 4 hrly'.* Under Mobilising: *'Able to weight bear Yes';* and under Other: *'Regular monitoring of pressure areas due to immobility'.* There are several comments written under the Review Comment column and only three of them are dated (7/11 and 14/11). The reviews include: under Sleeping (undated): '*2 hrly because of pressure sore for safety'* and under Mobilising (7/11) *'Requires hoist to transfer, unable to weight bear'.* The reviews appear to have been written by [Ms E].

The Short Term Care Plan stated under Dietary Needs: *'Encourage to feed herself and offer fluids'.* The Lifestyle Plan states under Eating and Drinking: *'Special die — Normal/Soft; Impaired Swallowing — yes; Assistance required — Yes; Diet Supplements — Yes (review on 14/11 — Nutritional supplement required'*. There is no documentation about [Mrs A] having oral thrush which can affect her eating ability in either care plan although it was ticked in the Resident Assessment Form.

From the documentation provided to me, [the Facility] have page 1 of 2 of the nursing referral from [Hospital 2] but not page 2; I do not know whether they were sent page 2 and have not included it in the bundle of documents provided or if they did not receive it from [Hospital 2]. [Hospital 2's] copy of Page 1 states under Dietary *'Slow to swallow; Light — Soft diet or sieved; Special (state) — Feed'* and [the Facility's]

copy of Page 1 has extra handwritten comments *'Sit up Straight Need Feeding, puréed'.* Page 2 states: *'Nutrition — is able at times with direction to feed herself, but we have found to maintain good nutrition & hydration feeding is necessary. Mobility is a two person transfer cannot weight bear and is unable to sit upright unless support by pillows for any length of time ... Skin integrity — sacral area reddened but intact regular positioning is necessary, while a [patient] with us she has been on an air mattress'.* There was no reference to the oral thrush on either page of the nursing referral.

When [Ms E] developed the care plans on the same day, she wrote conflicting information from one plan to the other eg 2 hourly and 4 hourly turns, encourage to feed herself and requires assistance and able to weight bear, unable to weight bear. I am unsure why [Ms E] developed both care plans on the same day as it leads to confusion as to which one to follow, particularly as [Ms E] documented on the short term care plan under Date of Care Plan: *'From — 28/10/05 to 11/11/05'.* Additionally, she wrote conflicting advice on the above care requirements in both care plans which would have led to more confusion for all caring staff. I would expect [Ms E] to have waited the three weeks in order to assess [Mrs A's] care needs for herself, particularly in view of the minimal information sent by [Hospital 2]. [Ms E] should also have used this time to obtain more information from [Hospital 2].

Input and assessments from all multidisciplinary staff caring for [Mrs A] i.e. Physiotherapist, caregivers, registered nurses and General Practitioner is essential to enable an appropriate Lifestyle Plan to be developed. [Mrs A] was assessed within 4 days of admission by the Physiotherapist: *'31/10/05 Am Physio/Initial assessment completed see enclosed. To transfer using standing twist 2 person'.* [Ms E] documented the Lifestyle Plan on 28 October 2005 well before the Physiotherapist could conduct her assessment of [Mrs A's] mobility and give advice as to her management. The Physiotherapist advised: *'To transfer using standing twist at present ... Please support right [illegible] at all times'*; this assessed mobility plan was not transposed into the Lifestyle Plan by [Ms E].

[Ms E] developed the initial wound charts on 7/11/05 which were for superficial sacral areas and were treated with *'Opsite — gel'.* [Ms E] states in her letter dated 29/10/06 to HDC: '*no pressure sore had developed prior to my going on leave ... I emphasized [Mrs A's] sacral sore needed to be closely monitored'.* These are conflicting statements within her letter and it is clear from the above notation on the wound chart that [Mrs A] did have a pressure sore, probably stage one, prior to [Ms E's] annual leave. [Ms E] went on three weeks annual leave from 16 November to 8 December 2005, according to the letter of complaint to HDC dated 20 December 2005 from [Ms B] *'When the Care Manager, [Ms E], went on holiday for three weeks from 17 November to 6 December.'* There is notation in the progress notes by a Registered Nurse on 22/11 which states: *'Decubitus ulcer on sacral area'*. The

wound management section on the wound chart is updated on 22/11/05 and states: *'ulcer repair Mebo get prn'* and under wound review on 28/11/05 *'ulcer / with smell'*. These limited notations give the assumption that [Mrs A's] pressure areas developed significantly during the period of [Ms E's] annual leave rather than while [Ms E] was overseeing [Mrs A's] care.

[Ms E] met with family on the 14/11/05 and discussed the following: *'I would try and allocate the same staff member to see to [Mrs A's] need; Weighs Weekly ... [Mrs A] has no sitting balance this would be hard to get an accurate reading. [The] (physio) would be working on this; [Mrs A] came in with a superficial sore on sacrum ... only required a protective dressings ... [Mrs A] needs to be kept off her sacrum at all times. She was very reluctant to do this and despite pillow, still manage to go back ... discussions about hiring a roho mattress, but this was only ideas, nothing had been definitely decided ... all our mattresses are pressure-relieving ... To encourage [Mrs A] to feed herself a lipped plate would be used'.* From the documentation available, [Mrs A] did have a sitting balance of 2 minutes and it is definitely possible to get an accurate weight during that time. Superficial sores (stage one) do only require protective dressings; however, it is vital that [Mrs A] was turned regularly and kept off her sacrum and the correct level of pressure relief mattress and cushion was used. The Apollo mattress is a lower level pressure relief system suitable for stage one and two pressure areas; however [Hospital 2] had been nursing [Mrs A] on an air mattress, a higher level of pressure relief than the Apollo, which they had obviously assessed her as requiring. [Ms E] had also identified that [Mrs A] was difficult to keep off her sacrum; therefore it was even more imperative that a higher level of pressure relief mattress and cushion were put in place to ensure that [Mrs A's] current pressure area did not deteriorate any further and in fact ideally would heal with additional pressure relief. There was no evidence that [Ms E] considered a pressure relief cushion at any stage of her involvement with [Mrs A]. It is clear that [Ms E] was involving the family with discussions about [Mrs A's] care needs and management.

In conclusion, in my opinion, [Ms E] delivered adequate care to [Mrs A] during the period of time before her annual leave commenced. She completed the Short Term Care Plan, Lifestyle Plan and review, completed wound charts and met with the family on the 14/11/05 to discuss [Mrs A]. However there were several inadequacies in the care [Ms E] provided, namely: lack of comprehensive/completed assessments and reassessments, conflicting care plans based on inadequate information about [Mrs A], inadequate understanding and provision of pressure relief mattresses and contractual requirements, lack of obtaining the appropriate pressure relief system, lack of requests for other health professional input eg dietitian and wound specialist nurse and lack of documentation within the progress notes. Some of these inadequacies may have occurred due to [Ms E's] excessive workload, lack of support and work output from the Registered Nurses and going on annual leave during this period of time.

2 Was the care provided by [the Facility] adequate and appropriate?

The care provided by [the Facility] was not adequate and at times inappropriate. In particular, the Registered Nurses did not give adequate and appropriate care.

The Registered Nurse Job Description requires under key functions: *'To co-ordinate nursing care and medical services for residents, in consultation with management'*. Under Responsibilities to Residents and Families: *'... that all admission details are completed and signed for; To develop a Short Term Care Plan within 24 hours of admission, the resident and/or their representative being consulted .... To complete an individual Lifestyle Plan within three weeks of a resident's admission and to ensure reviews occur ... To facilitate access to primary health care through the GP and other health care professionals as required. All such visits to be requested and documented by staff'.* Under Responsibilities for Primary Health Care: *'To liaise with management (or, when not available) arrange with the GP directly, for a visit to be made should a resident's condition give concern; To ensure assessment details are maintained for all residents and reviewed on a regular basis, in order to meet contractual and auditing requirements; To maintain a record of weights and blood pressure recordings on a monthly basis or co-ordinate staff to do so; To carry out any nursing care procedures which may include wound care ...; To carry out doctors' prescribed treatments or medications ...; to ensure that new medications are ordered and dispensed as per documented procedures.'* Under Responsibilities for Staff: *'To ensure all documentation is completed and relevant information passed onto next shift'.*

The Registered Nurses had the responsibility for the daily provision of clinical care including assessment and reassessment with appropriate care planning to meet [Mrs A's] care needs. They also had the responsibility for delegation and supervision of any nursing care related activities to the caregivers and liaison with other health professionals. Apart from the assessment conducted on admission, there is no evidence of any reassessment to base any changes in the Lifestyle Plan or to determine whether other health professionals' input such as a dietitian or extra equipment such as a higher level pressure relief mattress and cushion should be obtained.

The night Registered Nurse admitted [Mrs A] and partially completed the Resident Assessment Form; this form was never completed by either a Registered Nurse or the Care Manager. Both care plans were developed by [Ms E] as discussed above. The wound charts were initially developed by [Ms E] and later updated by the Registered Nurses; these were inadequate as discussed further under question seven. Documentation from both the Registered Nurses and the caregivers was substandard, refer to question 10.

There is a separate goal sheet with three goals written on 25/11/05, one month after admission, there is no identification of who wrote these goals. Two of the goals stated: *'Referral to be made for nutritional supplement; Decision on Pressure relief mattress to be made by 30/11/05'*, neither of these goals were achieved. The third goal was to weigh [Mrs A] on Mondays. [Mrs A] had been weighed initially on the 21/11/05 *'[Mrs A] also weighed today 45kg',* then again on the 1.12.05 *'Weighed today at the request of [Dr D]. Weight 41.5kg'.*

There is no evidence within the documentation that the Registered Nurses discussed the need for or requested Dietitian involvement and higher level pressure relief at any stage of [Mrs A's] stay with either [Ms E] or management while [Ms E] was on annual leave.

[Mrs A] was apparently admitted with oral thrush as I note that the night Registered Nurse ticked [Mrs A's] Resident Assessment Form for oral thrush. The Short Term Care Plan and Lifestyle Plan do not have any reference to [Mrs A] having oral thrush and there is no notation within the progress notes or Resident Reports about [Mrs A] and her ongoing oral thrush problem. The only other references I could find within the bundle of documents about the Nilstat was on [Ms B's] email to [the Facility] management dated Friday 2 December 2005 and it states: *'Oral Thrush — new prescript of Nilstat in'*[21] and on [Hospital 2's] Discharge and Coding Summary: *'Nilstat oral suspension, 1 ml qid, 1 month (script given)'.* [Mrs A] clearly had an ongoing oral thrush problem which was clearly not being cared for adequately as oral thrush should have cleared up with the Nilstat, or if required another antifungal oral suspension; this would have impacted on her appetite and ability to eat adequate meals.

The lack of oral and dietary care, adequate ongoing dietary assessment, provision of nutritional supplements and pressure relief equipment was not acceptable in a residential hospital setting. The responsibility is that of the Registered Nurses to assess [Mrs A's] care needs and to refer to the appropriate health professional or to obtain the appropriate equipment with management input.

There is no evidence that the Registered Nurses conducted a pain assessment and developed a pain care plan despite some documentation within the progress notes indicating [Mrs A] was experiencing pain and her daughter's request for pain relief, refer to question 5. The Registered Nurses are responsible to ensure they adequately assess and put in place care plans to meet [Mrs A's] identified needs.

The Registered Nurses did not ensure that caregivers wrote in [Mrs A's] progress notes on a regular basis or when there must have been concerns about her health status, refer to question 10.

[21] On 2 December 2005 Ms B emailed the Facility a copy of the notes she made following the family meeting held on 14 November. Ms B noted that a new prescription of Nilstat was in and Ms E would check that it had been taken.

Care delivered to [Mrs A] from the caregivers is more difficult to determine. They completed the Daily Resident Review which is a list of Activities of Daily Living (ADLs) where they document using codes and ticks. This document does not allow any concerns to be covered in it. The documentation within the progress notes by care staff is very sporadic and unacceptable, refer to question 10. The poor level of documentation meant precise information was not written about [Mrs A] which would not assist the Registered Nurses in their decision making with care requirements.

[Ms E] states in her letter dated 20/10/06 to HDC that the Dementia Unit Care Manager, [Ms I] and the General Manager [Ms H], were left in charge of the hospital residents while she was on annual leave: *'Prior to my going on leave I left clear instructions with the Care Manager from the Dementia Unit, [Ms I], whom with the General Manager [Ms H] were left in charge of my residents'.* There is no evidence that the Registered Nurses and [Ms I] liaised together on a regular basis during this time, or that the General Manager had any contact with the Registered Nurses over [Mrs A]. [Ms B] stated in her letter dated 20 December 2005 to HDC: *'When the Care Manager, [Ms E], went on holiday for three weeks ... We were told that [Ms H] would be in charge of the hospital, but it appeared that the day to day running of [the Facility] was left to the duty RN. There was no one acting as manager in a 'hands on' capacity until [Ms I], the Manager from the attached Dementia Unit, became involved to sort out problems that had developed in [Ms E's] absence'.* I would expect that management would ensure a designated management person liaised with the Registered Nurses on a daily basis from Monday to Friday and would assist the Registered Nurses to deal with any concerns that arose prior to them becoming issues.

[The Facility's] Pressure Area Care Policy states: *'Where it has been identified that there is an increased risk of pressure areas developing, all necessary cares and specialised equipment will be employed in an effort to reduce that risk. We will supply equipment such as pressure mattresses, Spenco boots, pressure cushions, to assist in minimizing the occurrence of pressures areas'.* [The Facility's] management did not ensure that staff abided by their policy and there is doubt as to whether management were supportive of staff and residents by ensuring the ready availability and provision of higher level pressure relief systems, including cushions.

In conclusion, I believe the care provided by [the Facility] by the Registered Nurses was substandard. As mentioned above, there is conflict between the Registered Nurse and Care Manager Job Descriptions with the Resident Care Planning & Monitoring Policy and this could have contributed to the apparent lack of action from the Registered Nurses, however it is not acceptable that Registered Nurses did not provide adequate and appropriate care to [Mrs A]. Documentation by care staff was very minimal and did not adequately address [Mrs A's] needs. It was the Registered

Nurses' responsibility to ensure that care staff completed all their work and documentation. I would rate this as moderate severity.

In addition, [the Facility] appeared to have not provided adequate support and guidance for the Registered Nurses on a daily basis while the Care Manager was on leave, nor did they provide adequate pressure relief mattresses and cushions for residents with higher needs. I would rate this as moderate severity.

3 Were the management systems, policies and procedures employed by [the Facility] adequate and appropriate?

The management systems, policies and procedures were not completely adequate and contained some conflicting information. [The Facility] has provided the following care related policies: Pressure Area Care Policy, Resident Care Planning & Monitoring Policy, Personal Cares Policy, Resident Assessment Policy, Skin Management Policy, Change of Resident's Condition Policy and [Wound Care Policy]. The Resident Care Planning & Monitoring Policy was written on 10/01/05 and was signed off; the remaining policies were written on 01/12/03 and were not signed off; the policies should have been signed off.

I was supplied with the Care Manager and Registered Nurse Job Descriptions on request. As discussed earlier, the job descriptions and the Resident Care Planning & Monitoring Policy were conflicting in their requirements of the Care Manager and Registered Nurses. The Resident Care Planning & Monitoring Policy was unclear as it stated a Daily Review Plan will supplement the progress notes whereas I assume the Daily Resident Review form to be the Plan in question, refer to question 10.

The Aged Related Residential Care Contract requires: *'Each Subsidised Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 3 weeks … At the time of admission an initial Care Plan is documented … Each Care Plan is developed, documented, and evaluated by a Registered Nurse within 3 weeks of the Subsidies Resident's admission'.* [The Facility's] Resident Care & Monitoring Policy requires a Short Term Care Plan to be developed within 24 hours of their admission, a Resident Assessment form to be completed within 72 hours of a resident's admission and the Lifestyle Plan to be developed within three weeks of admission; this policy does not fully comply with the Contract requirements.

The Resident Assessment Form combines a comprehensive list of assessments to be completed by ticking and commenting, although there is little room for comments. The layout of the form is unusual in that it includes a comprehensive social history, life history and activities section which is normally completed by an Activities Officer at this level of comprehension. I would only expect an overview of the social history to be completed by the Registered Nurses After this section, the assessment continues for level of

personal ability, mobility, skin, pressure area risk evaluation, dietary and medication. I would have expected the mobility section to be next to the physical assessment section at the beginning of the form. I believe that this Assessment Form is unwieldy and user unfriendly.

In addition, the Assessment Form includes falls risk and pressure area risk evaluations (Waterlow) which are normally conducted as separate assessments at the time of the nursing assessment or within the three weeks from admission. By using a separate form for these, it is much easier to reassess them as their condition changes. The Assessment Form contains a basic incontinence assessment — if it is identified that the resident is incontinent, a separate more comprehensive assessment should be undertaken, including a '24 hour' diary preferably documented over 3–5 days but at least 24 hours. Separate nutritional and pain assessments should be undertaken over the initial three week period following admission, if there were concerns identified at admission, or when a resident's condition changes. The long term care plan (Lifestyle Plan) should then be developed with the additional information obtained from these comprehensive assessments.

There is a section within the Resident Assessment Form for pain assessment, this is a very basic assessment which should be used to identify if a more comprehensive pain assessment is required. I have not been provided with a separate pain assessment form so am unsure whether there is one available for the Registered Nurses. I would expect a separate more comprehensive pain assessment tool to be available so that the Registered Nurses can complete pain assessments on residents any time they require one.

In conclusion, the Resident Assessment Form is adequate but very unwieldy and user unfriendly. The form does not allow for reassessment, unless a new Resident Assessment Form was completed, at each Lifestyle Plan (long term care plan) 6 monthly review or earlier as required. I would recommend a revamp of this form to assist the Registered Nurses.

The Short Term Care Plan format is very brief and gives little information for caregivers to follow. The Lifestyle Plan does not meet the requirements of a long term care plan which should document problems/needs/strengths with associated goals and interventions. The Lifestyle Plan is really just a task list for the caregivers which you would expect to find in the wardrobe for the daily tasks.

The Wound Chart is inadequate in its design. There is no comprehensive wound assessment and the layout prevents staff from completing a comprehensive wound chart. There should also be a short term care plan designed for skin tears, superficial wounds, infections, etc that require input for 1–2 weeks only, then if they continue after that date, they should be documented on long term care plans such as the Wound Chart

and Lifestyle Plan. Neither format of the Wound Chart or the Lifestyle Plan allows this or prompts it from staff.

The system for staff to obtain equipment such as individually required pressure relief mattresses and cushions is not documented in the policies provided and was clearly not explained to [Ms E]. It also appears that staff had difficulty in obtaining management permission for an alternative and higher pressure relief mattress and cushion to be obtained for [Mrs A]. [Ms E] commented in her letter dated 29/10/06 to HDC: *'As previously explained the mattress provided, was felt, by the management to be adequate for all pressure area needs'*. As discussed under question 4, Invacare are quite clear in their catalogue that the Apollo is designed for pressure relief of stage 1 and 2 pressure areas and not stage 4 pressure areas as [Mrs A] developed.

The Medication Policies are comprehensive and adequate, however there are areas that are not covered within the policies which should be. The Medication Management Policy does not clearly identify where oral antibiotics and eye drops should be signed for, unless they believe they come under *'prescribed creams, ointments and lotions'*. There is no reference as to where all regular liquid and powdered medication, such as Paracetamol Elixir and Metamucil, is signed for. There is no reference in the policy in relation to when a resident refuses medication and the procedure to document this occurrence. I note that the Medication Changes Policy allows the Care Manager/Registered Nurse to alter the medication packs: *'Medication packs/trays are to be altered by the Care Manager/Registered Nurse in special circumstances ONLY'*. Medication packs should only be altered by the Pharmacy and not [the Facility] staff.

The medication system used by [the Facility] is the Medico Pak system. The Administration Record (Signing Sheet) provided by [the] Pharmacy does not state the medications within the Medico Pack. Staff are essentially signing for a medication pack on a sheet which does not identify what medication they are signing for. When changes/additions are made to the Medico Pak, the Pharmacy should supply a new Administration Record with the list of medications and times to be given stated on it; staff should then use this new Administration Record to sign for all drugs. For additions, the Pharmacy could supply a second pack to compliment the main pack, this is common for short course medication such as antibiotics and again this pack should be supplied with its own signing sheet. In [Mrs A's] case, she clearly had extra medication prescribed outside the new monthly pack; there are no new/extra Administration Records for the staff to sign. There is no proof or [the Facility] audit trail that any medication changes/additions actually occurred and were administered to the resident; this system is inadequate and requires reviewing with the Pharmacy.

The Pressure Area Care Policy states: *'On admission, all residents will have a pressure area assessment completed and staff will be made aware of the findings. This is part of the main assessment completed by the Care Manager/Registered*

Nurse'. This policy also conflicts with the Resident Care Planning and Monitoring Policy where it stated the Care Manager is responsible for the initial assessment on admission. This policy does not talk about reassessment as residents' needs change and is not linked to the Skin Management Policy. The Skin Management Policy states: *'Where necessary a registered nurse will complete a Pressure Area Risk Evaluation Form'.* This policy does have links to the Wound Management and Pressure Area Care Policies. These two policies are not clear enough in what is expected and by whom in relation to pressure area prevention, assessment and management and require careful revision and linkage with all associated policies and job descriptions to ensure continuity.

Nutritional requirements are documented in several policies. The Nutrition Policy details the procedures for residents' nutritional needs. The Pressures Area Care Policy states: *'Every effort will be made to ensure that the nutritional and hydration needs of residents are met'.* The Personal Cares Policy states: *'Residents will be assisted with feeding and drinking if they are unable to manage these tasks for themselves'*. None of these policies are linked to each other.

The Complaints/Concerns Policy is well detailed, although it does not detail how to deal with concerns raised that are not written up as complaints.

Overall, [the Facility] had well detailed policies and procedures, however, there is conflicting information within some of them and related job descriptions and not all policies are linked with other relevant policies. The policies state procedures but are not clear as to how the staff carry out some procedures such as accessing alternative pressure relief systems. The Resident Assessment, although detailed, is unwieldy and user unfriendly. The Lifestyle Plan does not meet long term care plan requirements and is also user unfriendly. The wound chart is inadequate as an assessment and management tool. There are no separate assessment tools for staff to assess/reassess as residents' needs change. The Medication Administration Record does not detail medications in the packs. Management and replacement procedure of the Care Manager's annual leave is not documented and unclear for Registered Nurses.

In conclusion, some of the management systems, policies and procedures are not completely adequate or appropriate. The Pharmacy Medico Pak system is not adequate. This would rate as mild severity for the policies and moderate severity for the assessment tools and care plans, pressure relief system, management of the Care Manager's annual leave and the Medico Pak system.

4 Was the Apollo mattress used appropriate to [Mrs A's] needs. Should an alternative been provided by [the Facility]? If so, at what time?

The Apollo mattress is called the Apollo Visco-elastic foam mattress and comes in either soft or standard. The Invacare catalogue describes is as: *'Apollo foam is sensitive to temperature and therefore reacts to the heat of the body and moulds to the exact contours, promoting optimum pressure relief, support and comfort. Use Apollo as standard mattress in hospital and homecare beds, or as your preferred aid in prevention of pressure sores. Features: Patients having pressure sores classified as stage 1 or 2 sores. Individual assessed to be at medium risk of developing pressure sores'.*

[Mrs A's] nursing referral from [Hospital 2] stated: *'Skin integrity — sacral area reddened but intact regular positioning is necessary; while a pt with us she has been on an air mattress'.* As mentioned previously, the second page (which this statement is written on) of the nursing referral is not with [Mrs A's] notes from [the Facility] so I am unable to determine whether [the Facility] received it; however, it is clear from the footer that there are meant to be two pages and I would have expected the Care Manager or a Registered Nurse to have contacted [Hospital 2] and have them fax the second page to them.

[Mrs A's] Pressure Area Risk Evaluation (Waterlow) was partially completed at the time of her admission. [Ms J] inaccurately assessed [Mrs A] as being restricted mobility whereas she was chair bound (unable to weight bear let alone walk) and her appetite as average when she clearly had a poor appetite due to her swallowing difficulty, tiredness, requiring feeding to maintain nutrition and with oral thrush. I have estimated her Waterlow as being 27 to 29 at the time of admission. I assessed her as this by noting her skin type appearance as discoloured (sacral redness on admission) and under Special Risks I scored her 5 for Cardiac Failure (IHD with MI in Dec 2004) and 4–6 for Motor/Sensory due to her hemiparesis; this along with the above changes to [Ms J] assessed as documented above, give the score as 27 to 29 which is very high risk.

The Apollo mattress is not designed for this type of risk and should have been replaced with a higher pressure relief mattress as soon as [the Facility] were able to obtain it; this should have been obtained within the first week. In the event that [the Facility] management was unable to recognize the need for a higher pressure relief system at the time of [Mrs A's] admission, a higher pressure relief system of mattress and cushion should have been provided as soon as [Mrs A's] sacral area became a stage 3 pressure area. Due to the poor documentation surrounding her sacral pressure areas, I am unable to determine the precise time the system should have been provided but I would assume it would have been during early November or at least by the 23 November when notation in the progress notes stated: *'Broken skin @ sacral area, developed into an ulcer'.* Certainly the Physiotherapist identified the need for pressure relief on the 18/11/05 *'Pressure relief to assist with current coccygeal/sacral*

pressure sore — ? Spenco'. It is important to note that a Spenco mattress and cushion are not suitable pressure relief for pressure area prevention or management of with high Waterlow scores associated with immobile residents. [Mrs A's] sacral pressure area shown on the Plastic Clinic's photo shows a grade of 4 *(cavity and/or sinus)*, refer to New Zealand Wound Care Catalogue January 2005 by Smith & Nephew, and I noted that [DHB 3] Rehab Progress Notes written on 14/2/06 confirm this as they state: *'The initial area is granulating & the sinus is healing slowly from the bottom'.*

In my opinion, staff at [the Facility] did not adequately assess [Mrs A's] pressure area risk nor request management to supply an appropriate specialised pressure relief mattress. I would rate this as moderate severity.

Were the medication administrations provided to [Mrs A] timely and correct according to the prescriptions?

The Drug Treatment Chart documents the medication prescribed by the General Practitioner (GP). Regular tablet medication and Metamucil powder were prescribed for 8am and 8pm on the 28/10/05. There is no evidence that [Mrs A] was administered the Metamucil as it has not been signed for on the Non Packaged or PRN Administration Record. PRN Paracetamol was charted on the 19/11/05 and charted regularly on 23/11/05 for 8am, 12n, 5pm and 8pm.

Nilstat Oral Suspension (for oral thrush) was charted on the 28/10/05 for 8am, 12n, 5pm and 8pm under Short Term Medications & Antibiotics but was not signed by the GP. As mentioned above in question two, it is apparent that [Hospital 2] transferred [Mrs A] with a script for the Nilstat; however I am unclear whether it was ever dispensed and administered. There is no documentation by the Registered Nurses on the Non Packaged or prn administration Record for the Nilstat ever having been administered to [Mrs A].

Multivitamins were prescribed on 23/11/05 by the GP and were clearly not dispensed by the 4-12-05 as evidenced by the Facsimile Cover Sheet which states: *'I'm faxing you [Mrs A's] drug chart. She doesn't have multivitamins in her drug folder. We have the liquid Paracetamol (caplets)'*. When administering medication, the Registered Nurse must check the medication in the pack against the Drug Treatment Chart, this clearly did not occur as it took eleven days for a Registered Nurse to notice that the Multivitamins were not in the pack; this is unacceptable.

The Medication Administration Record (Signing Sheet) has not been completed for every required documentation. Interestingly, medication has been signed as given under the Dinner (5pm) slot from the 28th October when no regular medication was prescribed for that time (except for the unsigned Nilstat oral suspension) until the Paracetamol on 23/11/05 and Erythromycin on 03/12/05. I cannot determine what tablet medication was in fact regularly given to [Mrs A] at 5pm from the 28th October

to until 22 November inclusive. The Medication Administration Record should only be signed for the pack medications, not oral medication.

[Mrs A] had left Hemiparesis requiring careful positioning of her left side; this can contribute to pain levels on turning and transferring or if not positioned correctly. Documentation within the progress notes was substandard and almost nonexistent in relation to pain. However, [Mrs A] clearly experienced pain and was able to communicate this to staff as evidenced through the minimal progress notes: *'15.11 appeared in pain (L) side when touched to move; 23/11 AM Pain upon movement. Panadol not tolerated well'*. Care staff should have been able to tell if [Mrs A] was in pain by watching her body language and should have documented any sign of pain that [Mrs A] experienced.

Acknowledgement that [Mrs A] was or could be in pain was also noted by the Physiotherapist: *'19/11/5 Physio….P) Cont rehab — 1. Pain relief'* and by the daughter: *'21/11/05 PM [Ms B] concern re — [Mrs A's] pain relief, if she could have pain relief regularly instead of prn as [Mrs A] is unable to tell if she's in pain or not; 22/11 AM Visited by daughter … Requesting too that [Dr D] should see [Mrs A] for … some changes in her panadol (from tablet to capsulized form); 2/12/05 pain on turning'*. Residents Reports *'19-11-05 Daughter wants to have pain relief. Pls fax the letter which is on the fax machine to [Dr D] to have the prescription for pain relief; 20/11/05 [Mrs A] pm meds not given discarded; 4-12/05 [Mrs A] follow-up fax drug chart to pharmacy. Make sure she get the multivitamins and the caplet paracetamol'* Facsimile Cover Sheet to Dr D: *'Hi!! the above mentioned lady is always in pain (according to the daughter) She wants her mom be prescribed with a pain relief medication. From [Hospital 2] medical record she was charted paracetamol 1 gm PRN the daughter wants it changed to liquid; 22-11-05 the daughter is requesting another change! SHE WANTS THE PANADOL IN CAPSULE FORM or any pain relief for that matter'.*

PRN Paracetamol was given on two occasions on 22/11; I am unable to read what times they were given. I also note that the progress notes on 28/12 (clearly should read 28/11) state: *'I gave her 10 ml Panadol syrup, as we are still waiting for her medication from the pharmacy'*. I am unclear why the Registered Nurse would have administered this Panadol without a prescription charted on [Mrs A's] Drug Treatment Chart and without a Medication Standing Order Policy which allowed residents to be given specifically GP authorized medications for residents not documented on their Drug Treatment Chart. In addition to this, I am presuming that the Registered Nurse used Paracetamol Elixir 250mg/5ml which is the standard Elixir used for adults. 10 mls of this Paracetamol Elixir is only 500mg of Paracetamol and the normal amount given to adults is 1gm (1000mg), so effectively [Mrs A] received half the normal dose. Of note is that [Hospital 2] gave scripts for all medication [Mrs A] was on except Paracetamol (refer to Medical Record A & R Discharge and Coding Summary).

The Admission Form states: *'Verbal Location of Pain — [Left] side shoulder arm & leg'.* The Lifestyle Plan under Controlling Pain on 28/10 states: *'Pain present — Yes, Type — Aching, Location — Shoulder, Pain Relief — Yes'.* The pain assessment on admission was only partially completed and the Lifestyle Plan does not mention the arm and leg pain. [Mrs A] was not reassessed for her pain and her Lifestyle Plan updated accordingly. It is quite clear that the Registered Nurses did not assess [Mrs A] for pain during her stay at [the Facility] and only requested pain relief at the insistence of the daughter. In fact it appears from the comment *'the above mentioned lady is always in pain (according to the daughter)'* that the Registered Nurses disbelieved the daughter and did not attempt to establish whether [Mrs A] did experience pain for themselves.

In conclusion, [Mrs A's] regular medication administrations were provided in a timely fashion according to the prescriptions; however, [Mrs A] was documented as having regular (tablet) medication at 5pm when I can find no evidence of a prescription. Not all medication administration has been signed for and it is unclear why — did [Mrs A] refuse it or did the Registered Nurse forget to sign for it. There is reference on one occasion that [Mrs A] did not receive her pm medication; no reason was given for not doing so; this notation was documented by night staff on the Residents Reports: *'[Mrs A] pm meds not given discarded'.*

PRN medication of Paracetamol was only documented as given twice when clearly she must have been experiencing pain. The multivitamins prescribed on 23/11/05 were not in [Mrs A's] drug folder on 4-12-05 and therefore were not ordered and/or dispensed in a timely fashion.

In conclusion there was compliance with medication administration but definite discrepancies/omissions. The Registered Nurses failed to assess and manage [Mrs A's] pain, have not ensured that newly prescribed medication was ordered and dispensed from the Pharmacy in a timely fashion, did not check medication they were administering against the Drug Treatment Chart, have not documented administration of non packaged medicines and have not always administered or signed they have administered pack medication or documented reasons for not administering them. I would rate this as moderate severity.

6 Was [Mrs A's] weight and nutritional needs adequately monitored and addressed?

[Mrs A's] nutritional requirements were poorly managed. As mentioned above, [Mrs A] was admitted with very poor swallow, required feeding to maintain good nutrition and hydration, required a soft/sieved or puréed diet and had oral thrush on admission and apparently still on 2 December 2005. [Mrs A] had a left hemiparesis: *'Nursing Referral — Diagnosis — ® CVA (L) Hemiparesis'*; this would also have increased her difficulty in feeding herself. [Ms E] documented in the Lifestyle Plan under Eating and Drinking *'Diet Supplements — Yes'* and in the progress notes on admission: *'28/10/05 nocte Puréed diet, needs feeding Needs to be sat upright for all intake food & fluids'.* On the second day the progress notes stated: '*28/12/05 PM Poor appetite; (Puréed food served + tomato soup); Difficulty swallowing noted'*. Again the progress notes stated: *'4/11 PM [Mrs A] ate her tea not much she didn't drink much; 4/11 nocte Push fluid as she is very dry'.*

[Ms E] and the night registered nurse, Ms J, both wrote that [Mrs A] was a normal/soft diet which is clearly not what [Hospital 2] had assessed her as. She was documented as having a very slow swallow and a normal/soft diet would be more difficult to swallow compared with a soft/sieved or puréed diet. Swallowing food would have been painful due to the oral thrush and although, as mentioned previously, the oral thrush was noted on admission, there was no follow up in documenting the oral thrush and management on either of the care plans.

A Residents Special Requirements Form was partially completed by ? family at some point (no signature or date documented on the form). This form requests more information *'so that the staff can meet cultural and care needs and the needs of your family'*. The form asks *'Are there different foods that could be provided and, if so, would staff be able to prepare these? Alternatively, are family able to supply these? Please detail favorite types of food'.* The answer states: *'Ensure to help increase body weight'.*

[The Facility] Nutrition Policy states: *'On admission, each resident will be weighed'*. In [Mrs A's] case, I would have expected her to be weighed within the first 24 hours of admission (due to her admission late at night) prior to the Short Term Care Plan development; this did not occur until the 21/11/05.

[Ms E] states in the family meeting on 14/11/05: '*Feeding/weighs weekly [Ms E]: I did say as [Mrs A] has no sitting balance this would be hard to get an accurate reading. [The] (physio) would be working on this'*. [Ms E] stated in her letter to HDC dated 29 March 2006: '*On admission, [Mrs A] was tired and frail as she arrived in the middle of the night. She had poor sitting balance at that time so we did not weigh her'*. The Physiotherapist's initial assessment on 31/10/05 stated: *'Able to sit unsupported for 2 mins'*. In my opinion, [Mrs A] should have been weighed

with two staff transferring her to the sitting scales or alternatively using a hoist transfer onto the sitting scales within 24 hours of admission as noted above. Should the staff have had difficulty recording an accurate weight, then [Mrs A] should have been weighed again with the assistance of the Physiotherapist and a Registered Nurse either on the Physiotherapist's initial assessment or her second visit to [Mrs A] on 4/11/05. Her sitting balance, as documented by the Physiotherapist, was enough to allow a weight to be taken for a base weight. Had [the Facility] provided hoist scales then it would have been very easy for [Mrs A] to have been weighed.

A weight chart should have been commenced documenting [Mrs A's] preadmission weight of 53 kg (as documented on her Assessment Form) and an initial weight taken by [the Facility] staff. Thereafter, I would expect [Mrs A] to be weighed every month as all residents should be. If there was a drop in weight or concerns that [Mrs A] was not eating enough then I would expect [Mrs A] to be weighed weekly. If there was any concern regarding [Mrs A's] nutritional intake within the first month, then I would expect [Mrs A] to have been weighed at that time and again on an ongoing weekly basis. As the Physiotherapist was regularly attending [Mrs A], she could have assisted the staff to weigh [Mrs A]. However, it is quite clear in the notes that [Mrs A] was able to be weighed, despite her poor sitting balance, as she was weighed on 21/11/05 *'[Mrs A] also weighed today 45kg'* and again on the GP's instructions on the 1/12/05 *'Weighed today at the request of [Dr D]. Weight 41.5kg. Doctor raised concerns regarding weight loss and has requested that [Mrs A] receive complan regularly'.*

When [Mrs A] was weighed on 21/11/05 with a weight of 45 kg, this demonstrated a loss of 8 kg from her previous weight as identified by the daughter on admission. This is a significant loss over a period of less than four weeks. [Mrs A] then lost another 3.5 kg within ten days when weighed on 1/12/05. [Mrs A] should have been commenced on a dietary supplement such as Ensure immediately on the 21/11/05 with an urgent referral to the Dietitian. The Registered Nurse on duty on 25/11/05 faxed [Dr D] requesting him to prescribe Arginaid and Fortisip as the daughter had requested it: *'[Mrs A's] daughter's requested the following — please — can you prescribe them for [Mrs A]. ARGINAID ... .FOR WOUND HEALING MANAGEMENT. FORTISIP — for weight management'.* The Registered Nurses should have assessed [Mrs A] as requiring nutritional supplements based on her weight loss, poor appetite, pressure areas, etc. They are health professionals and should be proactively assessing and caring for [Mrs A] and not just responding to her daughter's requests. It is unacceptable that no action was taken by [the Facility] staff until requested by the daughter and then told to by [Dr D].

On admission, the Nursing Referral from [Hospital 2] identified that [Mrs A] had a slow swallow and required feeding: *'Dietary Slow to swallow; Special (State) Feed; Sit up straight Need feeding'*. The Resident Admission Form also identified that [Mrs A]

was unable to feed herself: '*Is the resident able to feed themselves? No'*. [The Facility's] Personal Cares Policy dated 01.12.03 states: '*Residents will be assisted with feeding and drinking if they are unable to manage these tasks for themselves'*. The Short Term Care Plan states: *'Encourage to feed herself and offer fluids'* and the Lifestyle Plan under Eating and Drinking states: *'Special diet: Normal/soft Diet supplements: yes'*. [the Facility's] Resident Care Planning & Monitoring Policy dated 10.01.05 states: *'Within 72 hours of a resident's admission a Care Manager will complete a Resident Assessment Form. This is a comprehensive document that will provide sufficient information on which to base a long term Lifestyle Plan'*. The Resident Assessment Form section on Dietary Management section has Heights and Ideal Weight Ranges for People over 65 years with boxes to be completed noting: *'present weight, changes in weight over last 3 months, weight loss, weight gain, stable, Dietician Referral Yes No'* to be ticked plus guidelines for when a Dietician referral is required; this assessment was not completed and only had the notation stating: *'Used to be 53'*, clearly [Mrs A's] previous weight".

In my opinion, based on the facts that [Mrs A] had a hemiparesis, a slow swallow, required feeding, oral thrush and was admitted with a reddened sacrum, [Mrs A's] nutritional state should have been assessed initially by a Registered Nurse or the Care Manager using a nutritional assessment form, then referred to the dietitian if required; or referred directly to the dietitian on admission. I would expect this nutritional assessment to have occurred within the first three weeks of admission and to be used as a basis to develop her long term dietary care plan. I would also expect a reassessment of her nutritional status when concerns were raised about her eating and with a significant weight loss, which must have been visible to the naked eye and with clothes becoming larger on her as she lost weight.

[Mrs A] clearly required dietary supplements soon after admission. As [Dr D] advised [the Facility] staff, only a Specialist is able to apply for the Special Authority from HealthPAC in order for the dietary supplements to be dispensed without cost to [the Facility]. *'26 Nov 2005 Fortisip (like ensure) has to be applied for by a specialist'*. Dietitians assess nutritional requirements for many people and when they identify a need for dietary supplements, they write to the Consultant involved with the particular person and request them to apply for the Special Authority; this generally takes two weeks to obtain from HealthPAC. Alternatively, the GP can also write to the Consultant requesting them to apply for a Special Authority. I would expect a residential hospital to provide dietary supplements such as Fortisip, Ensure Plus, Resource Plus or protein powder such as Protafar to at risk residents while this process is undertaken. Some Dietitians are also able to give [the Facility] a small supply of dietary supplements to use while the Special Authority is applied for. I note that [the Facility] in fact did supply [Mrs A] with some Ensure *'1/12/05 PM Ensure given as food supplement to help*

(increase) [Mrs A's] weight'; this is prior to the application which was made on 6/12/05.

Management of nutrition for residents is important for residents' wellbeing and health status and to prevent development of wounds and pressure areas. Julian Jensen and Moira Styles, Dietitians, produced their second edition book 'Quality Food and Nutrition Services' in 1996. This book is available for residential hospitals to purchase and gives excellent information on nutrition for residents, including assessment and care plans. They state: *'Unplanned weight loss of 2 kg or more in one month must be investigated. Re-weigh the resident and consult dietitian or doctor'.* As mentioned previously [Mrs A] had an unplanned weight loss of 8 kg in less than four weeks.

Luckmann and Sorensens's Medical-Surgical Nursing, A Psychophysiologic Approach, 1974, states: *'Groups of patients who are particularly susceptible to the development of pressure sores are the following: .... very thin emaciated patients whose skin lies in a thin layer over the body's bony prominences, malnourished patients with protein and vitamin deficiencies'.*

Linda Russell (Tissue Viability Nurse Specialist, Queen's Hospital, Burtons Hospitals, NHS Trust, Belvedere Road, Burton on Trent, England) wrote 'The importance of patients' nutritional status in wound healing' (British Journal of Nursing, 2001, (Supplement) Vol 10, N0 6). She states '*High exudate loss can result in a deficit of as much as 100g of protein in one day. This subsequently needs to be replaced with a high protein diet*'. She also goes on to say '*There is a correlation between low serum albumin* (protein) *and body mass index (BMI) and the development of pressure ulcers ... Holistic assessment of nutrition and early detection of malnutrition are essential to promote effective wound healing*'.

In conclusion, [Mrs A's] weight and nutritional needs were not adequately monitored and addressed by the Registered Nurses. I rate these actions as moderately severe.

7 Was [Mrs A's] sacral area adequately monitored, treated and addressed in a timely manner?

[Mrs A's] skin integrity and pressure areas were poorly managed. [Mrs A] had a reddened sacrum on admission which would instantly alert a Registered Nurse that [Mrs A] was at risk of pressure areas. An inaccurate and partially completed Waterlow was also done on admission; this should have been completed and revised as she developed the pressure areas. The documentation within the progress notes is of very poor standard and it is difficult to obtain a clear picture of the developmental stages of the pressure areas.

[Ms E] developed a wound chart on the 7/11/05 and reviewed it on the 10/11/05 for a sacral area. It states: '*Size — 2cm; Type — superficial; Treatment required —*

Opsite Gel; Frequency PRN; Review date — 9/11/05 and 14/11/05'. This sacral area was not reviewed on the 14/1//05 but was reviewed on the 22/11/05. The second wound chart was developed by [Ms E] on the 7//1//05 for a sacral area and states: '*7//11/05 Size — small; Type — broken area & a bit sloughy; Treatment required — cleansed (with) NCC (Normal Saline) + covered with opsite; Frequency — PRN'.* There was no review date identified and this was not reviewed until 24/11//05. The wound charts do not clearly assess or identify the initial areas or changes in the areas, nor do they identify appropriate wound dressings. It is important to carefully assess the pressure areas including whether sloughy, necrotic, depth and size of wound, whether exudating or dry, infected or clean in order to identify the appropriate primary and secondary dressings.

On viewing the photo of the sacral pressure area taken by Plastic Clinic, it is clear that the wound dressings used by [the Facility] were not appropriate. I acknowledge that the available wound chart does not lead the Registered Nurse to accurately assess the areas or allow them to fully document them; however they could do so within the progress notes. Wound catalogues and wall charts are available from companies such as Smith and Nephew's New Zealand Wound Care Catalogue January 2005 (or previous catalogues) for them to refer to. Likewise, the company reps are also very happy to assist with suggestions for wound management and are available by telephone. Advice on wound management can also be obtained from Wound Specialist Nurses who are generally only too happy to give some advice over the phone. Wound management is a holistic approach including appropriate and adequate nutrition and pressure relief to prevent and/or heal pressure areas.

In view of the extent and severity of the pressure areas, [Mrs A] had, she must have experienced reasonable pain during dressing changes and would have required regular analgesia. However, if [Mrs A] had decreased sensation in her sacral area due to her CVA, then assessment and care of [Mrs A's] sacral area was even more important.

In conclusion, [Mrs A's] wound management and dressings were done by both the Care Manager and the Registered Nurses as above; they were not adequate to meet her needs. Likewise [Mrs A] did not receive adequate care in relation to her nutritional requirements or adequate pressure relief as documented above in questions four and six. I rate this as moderate severity.

8 Are there any aspects of the care provided by [Ms E] and [the Facility] that you consider warrant additional comment?

As discussed above, it appears that the Care Manager undertook the Registered Nurse responsibilities in long term care planning and wound management to meet [Mrs A's] care needs, whereas it was clearly the responsibility of the Registered Nurses employed within the hospital wing. The Care Manager's role was to oversee the quality of the care and ensure appropriately trained staff provided it. The discrepancies and confusion

between the roles of the Care Manager and Registered Nurse in the job descriptions and the Resident Care Planning & Monitoring Policy has obviously created confusion and they need to be reviewed and clearly defined by Governance, taking into account an acceptable workload for the Care Manager.

I noted that [Ms E] was required to work a minimum of 40 hours per week; this is more than usually expected from any member of staff in residential care and additionally she was also expected to be on call as negotiated. The implication I take from the requirement to work a minimum of 40 hours per week is that [Ms E] was in fact expected to work more hours than 40 hours per week at times if not regularly; I would consider this to be a very heavy workload. I also noted that on the new Assistant Manager Job Description dated 16.02.06 still requires a minimum of 40 hours per week. I would not expect a management role at the Care Manager/Assistant Manager level to have a requirement of a minimum of 40 hours plus on call. The assigned workload should be realistic and able to be managed within a 40 hour week generally. I am aware that at times, there would be acute situations requiring extra work time but working over 40 hours per week should not be the norm. I recommend that Governance look at the workload of the Assistant Manager (taking over from the disestablished Care Manager role) with a view to a realistic workload and not expecting this person to work over 40 hours per week, apart from the negotiated on-call, as the normal.

I am concerned by the attitude of [the Facility's] management. [Ms G], Director of Aged Care Services stated the following in her letter dated 21 July 2006 to HDC: '*I would be interested to know if she has increased in weight and whether her pressure areas have since healed. The reason that I am interested in this is that very frail elderly people do lose weight and can develop pressure areas — even with <u>good</u> care, particularly when they are nearing the end of their lives. If these factors are still present then this would indicate that even with good care, these factors may not have been preventable'.* I disagree with this view and believe that with excellent nutrition, good pressure relief systems that are applicable to the individual's needs, good assessment, care planning and implementation including 2 hourly turns, and with the multidisciplinary input of other health professionals such as Dietitian, Physiotherapist and Occupational Therapist, pressure areas are definitely preventable and no elderly person should be subjected to pressure areas such as those [Mrs A] experienced.

9 What standards apply in this case?

The standards that apply in this case are: Health Practitioners Competence Assurance Act 2003, Health and Disability Standards 2001, Nursing Council Code of Conduct for Nurses and Midwives 2001 and [District Health Board 3's] Aged Related Residential Care Contract.

10 Was the documentation adequate?

On admission, [Ms J], the night duty registered nurse, formally admitted [Mrs A] filling out the Resident Assessment Form which included a partially completed and inaccurate Waterlow (pressure risk) score *'Mobility Restricted'* when [Mrs A] was chair bound. The Assessment Form also included a Fall Risk Evaluation which was partially completed. [Mrs A] was noted to have difficulties with mobility *'Requires — 2 person assistance, cannot weight bear';* care issues, including her swallow and feeding *'Difficulty swallowing — very slow; Is the resident able to feed themselves? — No; Dietary — Normal, Pureed; Food consistency: Normal, puréed'*; and a reddened sacral area *'Red areas — sacral area; Comments: — 2hrly turns.* A restraint (consent) form was completed and signed by Ms B; no restraint assessment form was completed.

Documentation in the progress notes occurred at irregular intervals mainly from Registered Nurses and the Physiotherapist. There are entries from other staff that I think are caregivers as follows: *'28/12 Am; 14/11 PM; 12/11 PM; 13/11 AM; 15/11 AM; 1/12/05 1500'*. I note that from the 7 November until 12 November, there were two entries from the Physiotherapist and no entries from [the Facility] staff and that there were no entries for five days from 25/11/05 1000 until 1/12/05 1500 recorded. The documentation did not occur on each shift and there were other occasions of no entries on a day.

The Resident Care Planning & Monitoring Policy requires care staff to record changes or issues relating to residents within the progress notes and document on a Daily Review Plan to supplement the notes: *'Progress notes will be completed by care staff. These will detail any changes to the resident or issues related to the Lifestyle Plan. Progress notes must be in chronological order, provide full explanations and be factual … Where possible, resident responses should be recorded. Issues should be documented as soon as possible to ensure accuracy … A Daily Review Plan will supplement the progress notes'.* The policy does not state how often documentation is required.

The level of documentation in [Mrs A's] progress notes is very poor for a hospital and I would expect documentation to occur on every shift by the caregiver and as required by the Registered Nurse. I would expect that the Registered Nurses ensured the progress notes were documented in at the end of every shift; caregivers should not

leave work until they have done so for all their residents. [the Facility] Registered Nurse job description also requires this to occur, it states: *'To ensure … that staff have completed all their work prior to reporting off duty. To ensure all documentation is completed and relevant information passed onto next shift'.*

I note that the caregivers documented on a Daily Resident Review Form (I assume this to be the Daily Review Plan which is referred to in the Resident Care Planning & Monitoring Policy) which is required to be completed each shift; this form was not completed for every shift on some days. The form requires either ticks or a code to be documented against Activities of Daily Living (ADL's) and pain with no room for comments. Under mobility there is a choice of codes: *'IND — independent, AR — assistance required and t — turned (T2 = 2 hrly, T4 = 4hrly).* The box in which to write the code only allows one code to be written, and in [Mrs A's] case, AR was documented on all entries except for T2 on the following night entries: *'10/11, 14/11, 16/11, 17/11'.* Under Eating on the Daily Resident Review Form, the codes only allow for: '*NBM — nil by mouth, W — ate well, F — ate fairly well, S — ate small amount only, NG — Naso gastric feeding'.* There is no allowance for caregivers to document whether [Mrs A] required feeding or self fed. Documenting on a Daily Resident Review Form is not sufficient to give a comprehensive written record of progress for the resident and as the policy defines (as above) this form is meant to be supplementary to the progress notes. In my view, I would not use a Daily Resident Review form as it is not necessary if full and accurate notation is made within the progress notes each shift and adds unnecessary work for the caregivers.

I reviewed documentation by [Ms E] in [Mrs A's] [the Facility] file. I have been able to identify two entries from [Ms E] in the progress notes during [Mrs A's] stay at [the Facility]. The first entry is documented on the 7/12/05 between the nocte and pm entries (no date or time documented) which states: *'Spoke to Plastics to confirm that [Mrs A] is turned 2 hourly, and only state out for short periods (1 hour at a time). All meals to be taken in dining room under supervision and food chart commenced'.* Second entry (again with no date or time) written after 9/12/05 entry states: *Transferred to [another] Hospital'.* [Ms E] appears to have documented about [Mrs A] on two other occasions 14/11/05 and 7/12/05; both being family meetings. I note that [Ms E] did not state the names of who attended these meetings.

I also noted that there was significant documentation on the Residents Reports Form which should have been documented in the progress notes and a reference to it only on the Residents Reports Form eg '*19/11/05 [Ms B] her daughter wants to feed by herself. Wants her to practice that …* This should be documented in the progress notes along with a plan to trial this and monitor her progress and ability to feed herself (and included on a short term care plan), and should be documented on the Residents Reports Form as '[Mrs A] — feeding, see notes'. I could not find any reference to the Residents Reports Form in the policies provided that would guide the Registered

Nurses and caregivers as to what level of documentation is acceptable and expected on this form.

The District Health Board Aged Related Residential Care Contract requires: *'You must ensure that every Care Giver or Registered Nurse maintains a written record of progress for each Subsidised Resident under the care of that Care Giver or Registered Nurse'.* Although it may be said that the level of documentation required under the contract does not specify where or how it should be documented or that it should be on each shift, it is expected and best practice within a hospital setting for a written record to be documented within the progress notes on each shift, and in fact I would also expect this level of documentation to occur in a rest home setting as well. In addition, [Mrs A] clearly had progressively deteriorating pressure areas, was not eating well and was clearly losing weight, accurate and full documentation each shift is even more important.

In conclusion, the level of documentation on a daily basis, including reassessment and updating of care plans, was substandard and needs to be addressed through the policies, education of staff and follow up audits to ensure staff are documenting at the level required. I rate these actions as moderately severe.

Jenny Baker"

Appendix 3

The following additional expert advice was obtained from general practitioner Dr Ian St George:

> "I stated in my report that "His peers should, I think, view his actions as a mild to moderate departure from the usual standard of care".
>
> I have MB ChB Otago 1965, FRACP, MRCGP, FRNZCGP, DipObstRCOG, DipEd, MD. I have been a general practitioner for 35 years, and during that time have cared for many of my patients who have moved into rest homes. I do not regard my qualifications as any more than those of a general practitioner who is experienced in this work.
>
> As I pointed out, there are a number of overseas-developed guidelines, "…for instance UK (National Health Service …) ... and Australia: http://www.joannabriggs.edu.au/best_practice/bp1.php". I quoted those guidelines simply as examples typical of many others. [Ms F] appears to be misguided in her understanding of the term "best practice" used by the Australian website — it is perhaps deceptive, as it does not mean some kind of gold standard of excellence, but practice based on best available evidence — as stated in evidence-based guidelines. Dunedin's "BPAC", for instance, publishes a journal sent to all general practitioners, called *Best Practice*. The standards are those of good practice — and any separation of nursing from medical standards is spurious — these are simply standards of good patient care.
>
> I understand [Dr D's] assertion that the general practitioner is not the leader of the rest home team, but not his claim that the nursing staff are autonomous. Teams may be egalitarian, but the members are interdependent, and that dependency requires good communication, and (dare I say it?) leadership. His comparing pressure area risk assessment with the requirement for regular meals, bathing and toileting is frivolous.
>
> I think it is the responsibility of every team member to ensure that proper standards are being maintained by all other team members.
>
> I accept that [Dr D's] contacts with [Mrs A] may not have been brief. When I wrote, "His documentation of his encounters with [Mrs A] also fall short of the ideal, but they may accurately portray the brevity of those encounters" I meant to imply no more than that the reason for brief notes *may have been* brief encounters.
>
> I did not try to reconcile discrepancies: I stated plainly, "I note the conflicting accounts of some matters — whether [Ms B] was present on 24 November,

whether [Dr D] refused to perform some examinations — and state here that I am not in a position to assess the credibility, from the papers, of either account".

…

I am delighted to read that [Dr D] has completed the educational requirements for FRNZCGP, hope he will soon complete his Fellowship, and note his stated experience in rest home care.

I reiterate what I wrote in February.

- '[Dr D] provided services of a barely adequate standard to [Mrs A].'
- 'The division of clinical care and responsibility must be clearly understood by doctor, nurses and management; [Dr D] quite properly states that the management of pressure areas is a nursing responsibility; the nurses in turn would be expected to alert the doctor of concerns. However, he was a member of the clinical team, and the team was caring for a vulnerable patient, and they should have been discussing nutrition and pressure area care.'
- 'The clinical standards that apply are those of good clinical management of nutrition and pressure areas in vulnerable patients.'"